

HOLDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the attending physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
				a. STATE West Virginia b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 64 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charleston	
				d. STREET ADDRESS 1438 - 6th Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Kathryn		First	Middle	Last	4. DATE OF DEATH June 6 1961
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1947	9. AGE (In years (last birthday)) 14 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) West Virginia	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert A. Abood				14. MOTHER'S MAIDEN NAME Virginia Kirk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <p style="margin-left: 20px;">PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myelogenous Leukemia INTERVAL BETWEEN ONSET AND DEATH 3 months</p> <p style="margin-left: 20px;">Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Septicemia 1 week</p> <p style="margin-left: 20px;">DUE TO DUE TO DUE TO</p> <p style="margin-left: 20px;">(c) _____</p> <p style="margin-left: 20px;">PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 3 1961 to June 6 1961 , that (I) (we) last saw the deceased alive on June 6 1961 , and that death occurred at 5:32 P.M. Fill in the causes and on the date stated above.					
22a. SIGNATURE <i>Richard E. Rieselbach</i>		ATTENDING PHYS. <input type="checkbox"/> M.D.		22b. DATE SIGNED 6/7/61	
22c. PHYSICIAN'S NAME (Type) RICHARD E. RIESELBACH, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 6-7-61		23b. DATE THEREOF Sunset Memorial Park		23d. LOCATION (City, town, or county) South Charleston, W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR DATE JUN 8 '61	
				25b. REGISTRAR'S SIGNATURE Arthur L. Thorne	

Summary

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C. L. H.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6885

CERTIFICATE OF DEATH

Reg. Dist. No.

06871

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b one month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C.		d. STREET ADDRESS 4122 Fessenden Street, N.W.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Nursing Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Nellie		First	Middle	Last	4. DATE OF DEATH JUNE 12	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 15, 1875	9. AGE (In years lost birthday) 86	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Treasury Dept.		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Mr. William H. Alder		14. MOTHER'S MAIDEN NAME W.Va.		15. SOCIAL SECURITY NO. None		16. INFORMANT Miss Frances J. Crown		
17. INFORMANT (Yes, no, or unknown) No		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral Vascular accident		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Address 14428 Colesville Rd. Silver Spring, Md.		
		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 331X		(b) DUE TO Hypertension Atherosclerotic Cerebral		INTERVAL BETWEEN ONSET AND DEATH 24 hours		
		(c) Vascular Disease Seizure						
20a. MEDICAL CERTIFICATION		20b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 4122 FESSENDEN ST. N.W.		20f. (City or town) Washington		(County) District of Columbia (State) DC
21. I certify that I attended the deceased from April 1, 1961 , to June 12, 1961 , that I last saw the deceased alive on June 12, 1961 , and that death occurred at 6:45 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Washington 16th & C						
ACTUAL SIGNATURE P.P. Andrews		DATE SIGNED 6-17-61						
PHYSICIAN'S NAME (Type) P.P. ANDREWS								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/14/61		22c. NAME OF CEMETERY OR CREMATORIUM Union Cemetery		22d. LOCATION (City, town, or county) Lovettsville, Virginia		(State) VA
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.		ADDRESS 8434 Georgia Avenue Silver Spring, Maryland		24a. REC'D BY REGISTRAR JUN 15 '61		24b. REGISTRAR'S SIGNATURE Clinton S. Krause		

RECEIVED FROM STATE BOARD OF HEALTH - BOSTON, MASS.

CERTIFICATE OF DEATH

DECEASED

DEATH CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06872

6886

CERTIFICATE OF DEATH

TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH e. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 114 days		e. STATE Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital				b. COUNTY Montgomery	
3. NAME OF DECEASED (Type or print) Mark		Fist	Middle	Last	Month Day Year
5. SEX Male		6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3-18-91	9. AGE (In years last birthday) 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) Kentucky	
13. FATHER'S NAME William R. ALLEN		14. MOTHER'S MAIDEN NAME Clara KEYES		12. CITIZEN OF WHAT COUNTRY USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give rank or date of service) No		16. SOCIAL SECURITY NO. 579-38-7559A (S)		17. INFORMANT Address Wm. O. Allen, same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma					
162.1 DUE TO Conditions, if any, which gave rise to immediate cause (b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that the (this hospital) attended the deceased from Feb. 19, 1961 to June 13, 1961 , that we last saw the deceased alive on June 13, 1961 , and that death occurred at 11:20PM , from the causes and on the date stated above					
22a. SIGNATURE <i>Paul G. Lineweaver</i>					
22c. PHYSICIAN'S NAME (Type) Paul G. LINWEAVER, JR., M.D., MC, USN		M.D.	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-16-61	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Ft. Lincoln Cemetery	23d. LOCATION (City, town or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>R. A. Pumphrey</i>		ADDRESS R. A. Pumphrey Funeral Home, Bethesda, Md.	25e. REC'D BY REGISTRAR DATE JUN 16 '61	25b. REGISTRAR'S SIGNATURE <i>Albert S. Kraus</i>	

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Montreal, Quebec, Ottawa, St. John's, V.C.C. 4-62-172

Montreal, Quebec, Ottawa, St. John's

Montreal, Quebec, Ottawa, St. John's

Vancouver

Montreal

Montreal, Quebec, Ottawa, St. John's, V.C.C. 4-62-172

Montreal

Vancouver

Toronto

Montreal

Montreal, Quebec, Ottawa, St. John's, V.C.C. 4-62-172

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4

VR A15 (4)
15M 9/60

1 hours after
M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6887

06873

Item 14 Film G289

7/3/61 ink

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6903 Oakridge Ave.		e. STREET ADDRESS 54 16903 Oakridge Ave. =	
3. NAME OF DECEASED (Type or print) DEAN		First JOHNSON	Middle ALMY
4. DATE OF DEATH June 23, 1961		Last ALMY	Month June
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Jan. 27, 1898		9. AGE (In years last birthday) 65 yrs. 4 mos.	10. IF UNDER 1 YEAR Months 4
			Days 26
11. BIRTHPLACE (County & State, or foreign country) Portsmouth, N. H.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	13. IF UNDER 24 HRS. Hours 26
14. MOTHER'S MAIDEN NAME Isabella Yates		15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give rank or grade of service) Yes Unknown	
17. INFORMANT Charles E. Almy		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell carcinoma of esophagus grade III DUE TO 150X Conditions, if any, which give rise to immediate cause (b) (c), stealing the underlying cause listed.	
19. WAS AUTOPSY PERFORMED? NO		INTERVAL BETWEEN ONSET AND DEATH 6 mo.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 10, 1961 to June 22, 1961 , that (I) (was) last saw the deceased alive on June 22, 1961 , and that death occurred at 7 A.M. from the causes and on the date stated above.		22b. DATE SIGNED 6-23-61	
22e. SIGNATURE Arnold McNitt		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) ARNOLD McNITT		22d. ADDRESS 1835 I Street, N. W., Washington, D.C.	
23e. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 6/27/61	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cem. Arlington, Virginia
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		23d. LOCATION (City, town or county) (State)	25e. REC'D BY REGISTRAR DATE JUN 27 '61
		ADDRESS Bethesda, Md.	25b. REGISTRAR'S SIGNATURE Arthur L. Kraus

Digitized by srujanika@gmail.com

.A.V.

Dear Mr. and Mrs. Gandy

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6888

06874

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits,
write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN 1b

4½ days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Hospital

3. NAME OF
DECEASED
(Type or print)

First Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Male

White

WIDOWED DIVORCED

6/20/81

9. AGE (In years
last birthday) 10. UNDER 1 YEAR

79 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Retired

Insurance Salesman

Iowa

U.S.A.

13. FATHER'S NAME

Philip Bacher

14. MOTHER'S MAIDEN NAME

Jenny Hickok

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

333-14-9120 Hilda Bacher(wifw)

Address

same as above

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.0

DUE TO

Cognitive heart failure

INTERVAL BETWEEN
ONSET AND DEATH

1 month

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

Arteriosclerotic heart disease

10 years

(c)

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.20d. INJURY OCCURRED
While Not While
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 1966 to June 12, 1961, that (I) (we) last
saw the deceased alive on June 11, 1961, and that death occurred at 8:28 A.M. from the causes and on the date stated above.

22a. SIGNATURE

G. Bowditch Hunter, Jr. M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED

June 12, 1961

22c. PHYSICIAN'S
NAME (Type)

G. Bowditch Hunter

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Cremation

23b. DATE THEREOF

6/14/61

23c. NAME OF CEMETERY OR CREMATORIAL

Fort Lincoln Creamtory

23d. LOCATION (City, town or county)

(State)

Prince George's Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

Warner E. Pumphrey, Inc.

Raymond A. Ziska

ADDRESS

8434 Georgia Avenue

Silver Spring, Md.

25e. REC'D BY REGISTRAR

DATE JUN 19 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

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REGISTRATION OF DEATHS: The law requires that the death certificate be executed within 24 hours after death.

HOSPITAL OR CODING PHYSICIAN: The law requires

REGISTRATION OF DEATHS: The law requires that the death certificate be executed within 24 hours after death.

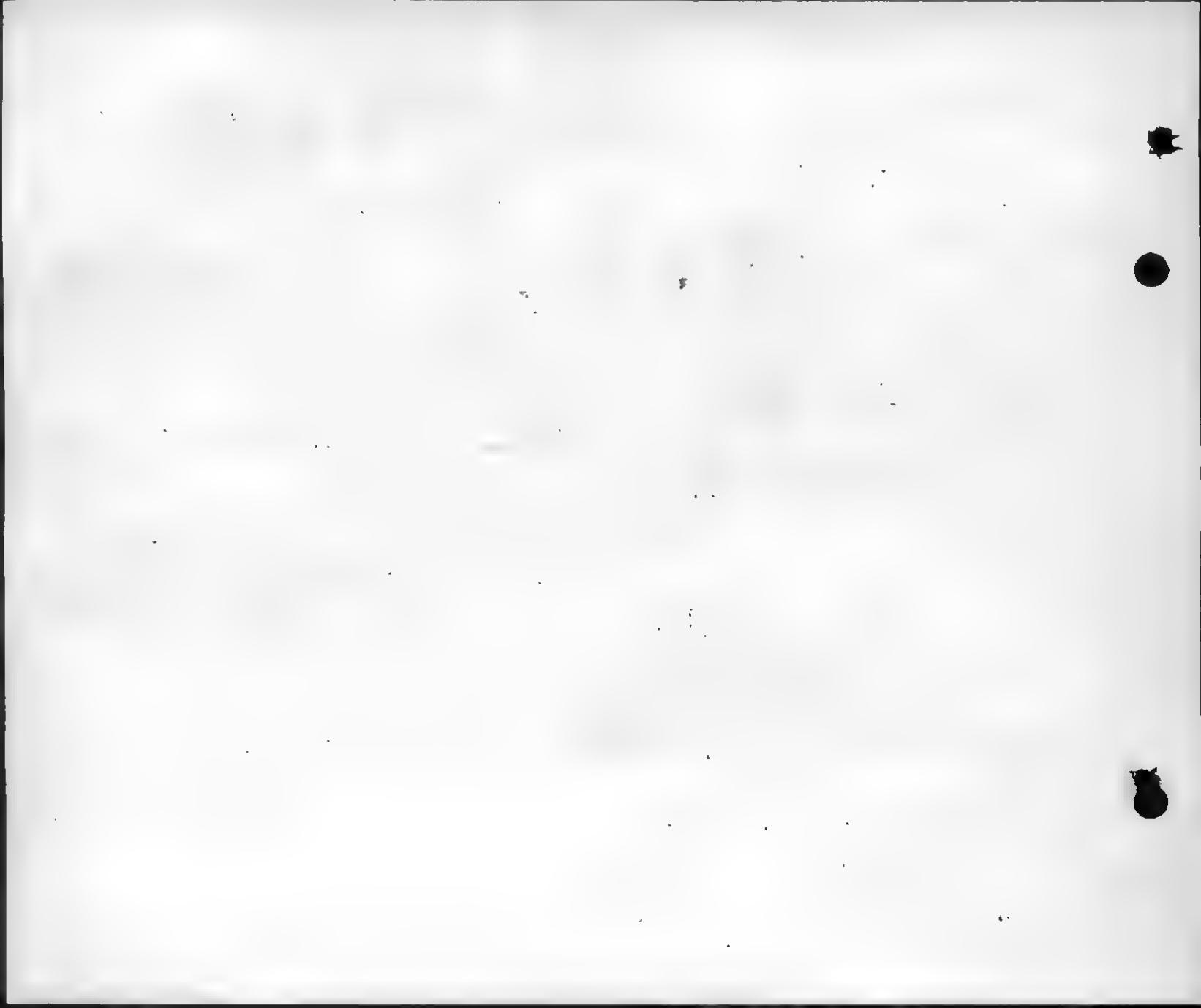
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6889 - Item 14 from G-001 6/27/01 iwk
CERTIFICATE OF DEATH

Reg. Dist. No.

06875

1. PLACE OF DEATH D. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
MONTGOMERY				a. STATE	Maryland
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b		b. COUNTY	MONTGOMERY
				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	46
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10404 Ga. Ave.		d. STREET ADDRESS 10404 Ga. Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY		First	Middle	Last	4. DATE OF DEATH BAKER
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1883	9. AGE (In years last birthday) yrs 78	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Russia	
				12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Elliot Baker		14. MOTHER'S MAIDEN NAME unknown		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		INFORMANT Rebecca Baker - 10404 Ga. Ave. S.S. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Part of Debefuction DUE TO (c) Carcinoma of Stomach & Metastasis DUE TO Bengui Disease				INTERVAL BETWEEN ONSET AND DEATH 4 days 2 weeks 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Blow to head		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o m p.m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Savage	(County) (State)
21. I certify that I attended the deceased from June 10, 1958, to June 21, 1961, that I last saw the deceased alive on June 20, 1961, and that death occurred at 7 A.M. from the causes and on the date stated above.				ADDRESS (Street, city, or town, state) 11412 Vieet Hill Rd, Wheaton, Md.	
ACTUAL SIGNATURE Francis X. Richardson		M.D.		DATE SIGNED 6/21/61	
PHYSICIAN'S NAME (Type) Francis X. Richardson					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/22/61		22c. NAME OF CEMETERY OR CREMATORIAL Ellesavetgrad Cemetery	
22d. LOCATION (City, town, or county) Wash. D.C.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE BERNARD DANZANSKY & SONS - 3501-14th St NW		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 23 '61	
				24b. REGISTRAR'S SIGNATURE Cynthia S. Thomas	



TO HOSPITAL ENDING PHYSICIAN: The law requires that the death certificate be signed by the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 4 should be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6820

06876

CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY **Montgomery**

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Bethesda**

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Suburban Hospital**

3. NAME OF
DECEASED
(Type or print)

First

Middle

MARY

JANE

BAKER

Last

4. DATE
OF
DEATH

June 15,

1961

5. SEX

6. COLOR OR RACE

Female

White

10a. USUAL OCCUPAT. ON (Give kind of work done during most of working life, even if retired) **School Teacher**

10b. KIND OF BUSINESS OR INDUSTRY **Teaching**

7. MARRIED NEVER MARRIED
WIDOWED DIVORCED

8. DATE OF BIRTH

Nov. 21, 1918

9. AGE (In years) IF UNDER 1 YEAR **42** yrs. IF UNDER 24 HRS.
last b'rthday **6** Months **24** Days **Hours** **M.n.**

13. FATHER'S NAME

Oscar H. Stitt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service) **No**

16. SOCIAL SECURITY NO. **Yes** 17. INFORMANT **Husband**

Unknown Robert J. Baker

Address

Same as Item #2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

592X DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Uremia

INTERVAL BETWEEN
ONSET AND DEATH

15 yrs.

Chronic Glomerulo Nephritis

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

19. WAS AUTOPSY
PERFORMED?

YES NO

20c. TIME OF INJURY Month, Day, Year
Hour a.m. **19** p.m.

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from **June 9, 1961** to **June 15, 1961**, that (I) (we) last saw the deceased alive on **June 15, 1961**, and that death occurred at **11:55 A.M.** from the causes and on the date stated above.

22a. SIGNATURE

DeWitt E. DeLawter
DeWitt E. DeLawter

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

6-15-61

22b. DATE
SIGNED

22c. PHYSICIAN'S
NAME (Type) **D. C.**

22d. ADDRESS

3848 Porter St., N.W., Washington,

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORI

23d. LOCATION (City, town or county)

(State)

Burial

6/19/61

Arlington Nat. Cem.

Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE

Robert A. Pumphrey

ADDRESS

Bethesda, Maryland

25a. REC'D BY REGISTRAR

JUN 19 '61

25b. REGISTRAR'S SIGNATURE

Charles S. Hayes



FOR STATE
MATH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6891

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06877

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Alberty

c. LENGTH OF STAY IN lb

00 A.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Montgomery Gen. Hosp

3. NAME OF
DECEASED

Tonia

Sail

Baker

4. SEX

6. COLOR OR RACE

Female white

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

5-31-61

WIDOWED

DIVORCED

9. AGE IN YEARS IF UNDER 1 YEAR
OLD (BIRTHDAY) MONTHS DAYS HOURS MIN.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF WHAT COUNTRY?

M.S.A

13. FATHER'S NAME

Donald Baker

14. MOTHER'S MAIDEN NAME

Virginia Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Virginia Baker (Mother) Item 2

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

475X
Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Asphyxia

after Respiratory infection

INTERVAL BETWEEN
ONSET AND DEATH

Found collapsed
in bed.

19. WAS AUTOPSY PERFORMED? YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

ACTUAL
SIGNATURE

Frank J. Broschart

M.D. ASSISTANT MEDICAL EXAMINER

EXAMINER'S
NAME (Type)

FRANK J. Broschart

DEPUTY MEDICAL EXAMINER

DATE SIGNED

Address (Street, city, town, or county)

6-23-61

22a. BURIAL, CREMATION
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR Crematory

22d. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Bethel H. Haight Hyattsville, Md.

DATE JUN 26 '61

Cathleen S. Kline



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

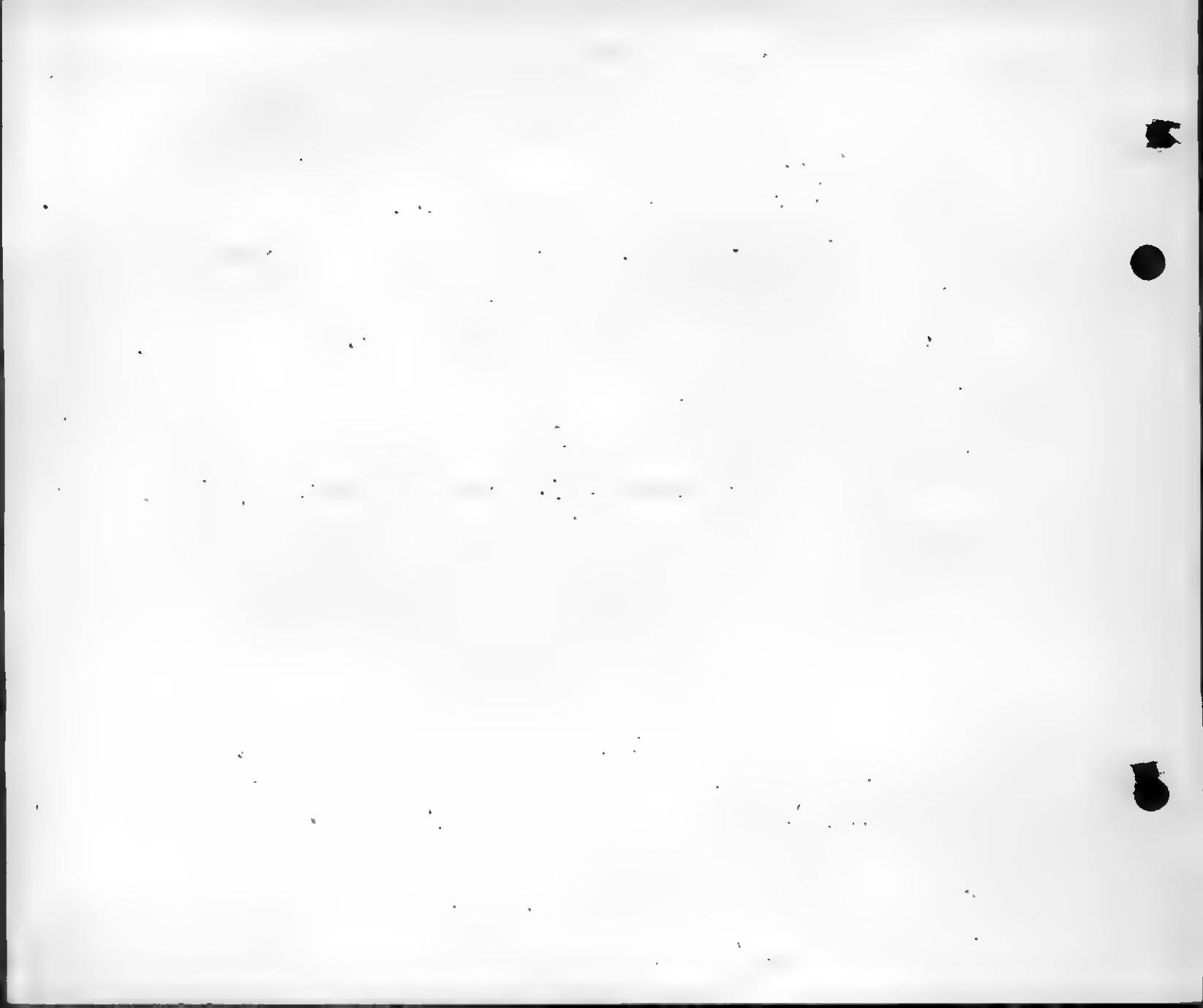
6892

CERTIFICATE OF DEATH

Reg. Dist. No. 06878

**HOSPITAL OR
HOSPITAL OR
TO FUNERAL DIRECTOR** may be retained
spiral or attending physician.
After this cert. form has been signed by the attending physician,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Montgomery		a. STATE DC	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GERMANTOWN	c. LENGTH OF STAY IN 1b	b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MARYLANDER REST HOME	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington DC		d. STREET ADDRESS 2306 Towson Rd
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MARGARET	Middle T.	Last Baptista
4. DATE OF DEATH	Month June	Day 11	Year 1961
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FE 6 3 1875
9. AGE (In years last birthday) 86 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY	12. BIRTHPLACE (State or foreign country) WASH. D.C.
13. CITIZEN OF WHAT COUNTRY? USA	14. FATHER'S NAME BENJAMIN F. Mc ALWEE		
15. MOTHER'S MAIDEN NAME	16. SOCIAL SECURITY NO. INFORMANT NEPHEW Address 4201 Brookside BENJAMIN V. Mc ALWEE MCLEAN VA		
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)			
DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 10, 1961, to 6/11, 1961, that I last saw the deceased alive on 6/19, 1961, and that death occurred at 8:50 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE James D. Kerr	ADDRESS (Street, city or town, state) Dennisaley, Md.		DATE SIGNED 6/11/61
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL DEATH	22b. DATE THEREOF 6-14-61	22c. NAME OF CEMETERY OR CREMATORIAL CONGRESSIONAL Cem.	22d. LOCATION (City, town, or county) WASHINGTON D.C. (State)
23. FUNERAL DIRECTOR'S SIGNATURE DeVol FUNERAL home	ADDRESS 2224 W St Ave	24a. REC'D BY REGISTRAR DATE JUN 19 '61	24b. REGISTRAR'S SIGNATURE Arthur S. French



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6893

CERTIFICATE OF DEATH

06875

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Suburban Hospital

**3. NAME OF
DECEASED
(Type or print)**

First

Middle

John

Franklin

Last

Barnes

4. DATE
OF
DEATH

Month

Day

Year

June

30

19 61

5. SEX

16. COLOR OR RACE

Male

White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

March 27, 1884

9. AGE (in years
(at birthday)
yrs.)

Months

Days

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Hours

Min.

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

District of Columbia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Barnes

14. MOTHER'S MAIDEN NAME

Rosa Queen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service)

Yes

1901

16. SOCIAL SECURITY NO.

17. INFORMANT

Son - Myer H. Barnes

Address **9608 Page Avenue**

Bethesda Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

33IX DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

(b) DUE TO

(c) DUE TO

Bronchopneumonia
Intracerebral hemorrhage 10 days

INTERVAL BETWEEN
ONSET AND DEATH

5 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

MEDICAL CERTIFICATION

20c. TIME OF INJURY Month, Day, Year

Hour a.m. Month

p.m. Day

19

20b. INJURY OCCURRED

White Not White

at work at work

20c. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

June 25th

21. I certify that (I) (this hospital) attended the deceased from June 25th, 1961, to June 30, 1961, that (I) (we) last saw the deceased alive on June 29, 1961, and that death occurred at P.M. from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

William T. Joyce, M. D.

ATTENDING PHYS

M.D. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

22d. ADDRESS

8106 Maple Ridge Rd.

Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Crem

7/3/61

23b. DATE THEREOF

Glennwood Crem.

23c. NAME OF CEMETERY OR CREMATORIUM

5703 Main

24. FUNERAL DIRECTOR'S SIGNATURE

Cherry Chase Funeral Home

ADDRESS

5703 Main

25a. REC'D BY REGISTRAR

Arthur E. Kline

25b. REGISTRAR'S SIGNATURE

DATE JUL 3 '61



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06880

6894

CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY
Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda (Rural)

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

U. S. Naval Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Betty

Baker

5. SEX

6. COLOR OR RACE

Female

Caucasian

W DOWED

NEVER MARRIED

DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

13. FATHER'S NAME

Norman Hempstead BAKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT
(Yes, no, or unknown) (If yes give rank & dates of service)

No

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Carcinoma, breast, with metastasis

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO
(b)

DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

INTERVAL BETWEEN
ONSET AND DEATH

3 yrs.

MEDICAL CERTIFICATION

2db. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

2db. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

2df. (City or town)

(County)

(State)

21. I certify that (a) (this hospital) attended the deceased from May 24, 1961 to June 14, 1961 that (b) (we) last saw the deceased alive on June 14, 1961, and that death occurred at M, from the causes and on the date stated above.

22c. SIGNATURE

James J. RYSKAMP, JR., LT, MC, USN

22c. PHYSICIAN'S
NAME (Type)

ATTENDING
PHYS.
MED.
DIRECTOR
22d. ADDRESS

STAFF
PHYS.
Arlington

DATE
SIGNED
6-14-61

23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial

23b. DATE THEREOF
6-16-61

23c. NAME OF CEMETERY OR CREMATORIAL
Arlington National

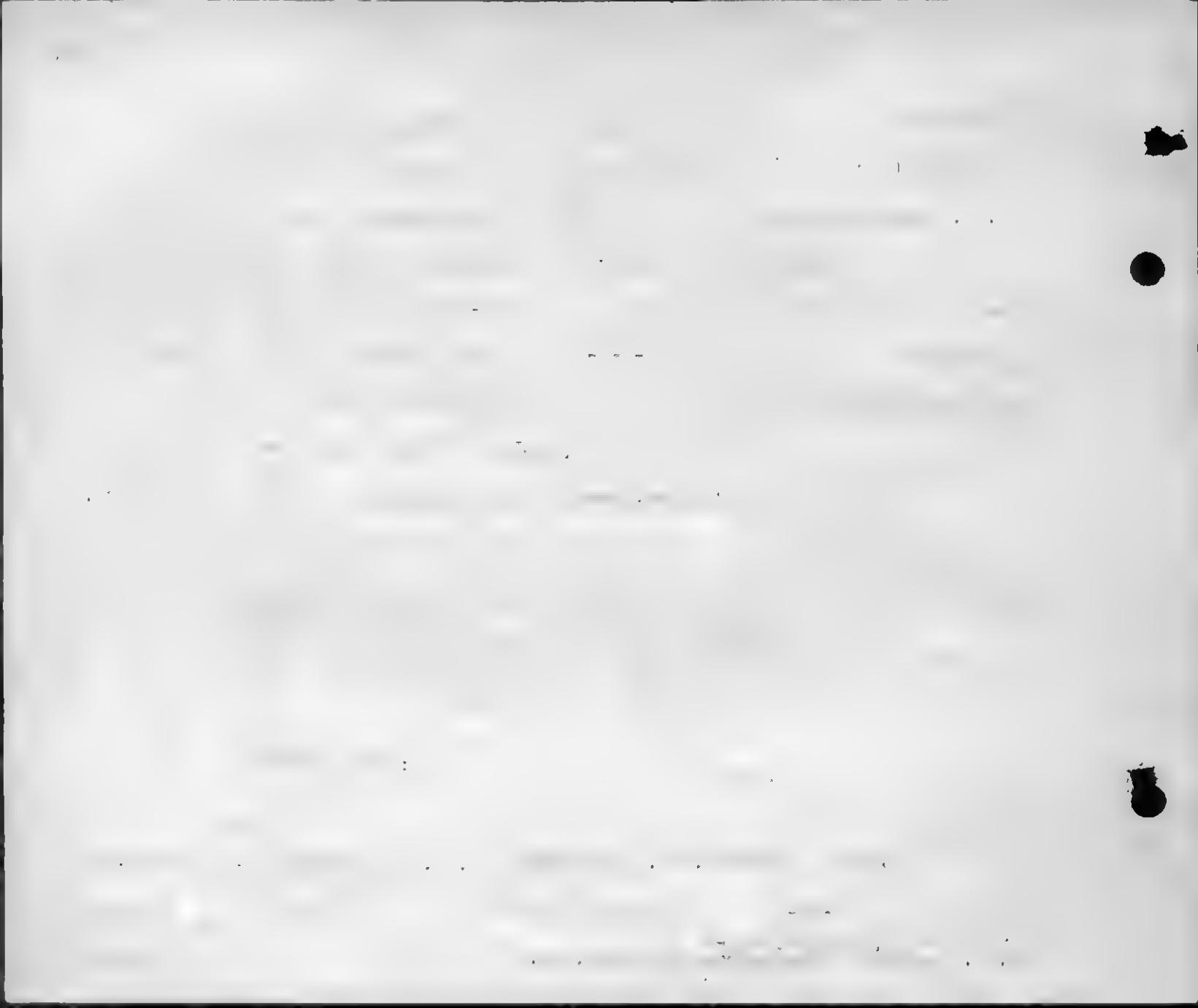
23d. LOCATION (City, town or county)
(State)
Arlington Virginia

24. FUNERAL DIRECTOR'S SIGNATURE
R. A. Pumphrey

ADDRESS

25e. REC'D BY REGISTRAR
DATE JUN 16 '61

25b. REGISTRAR'S SIGNATURE
Arthur S. Thomas



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

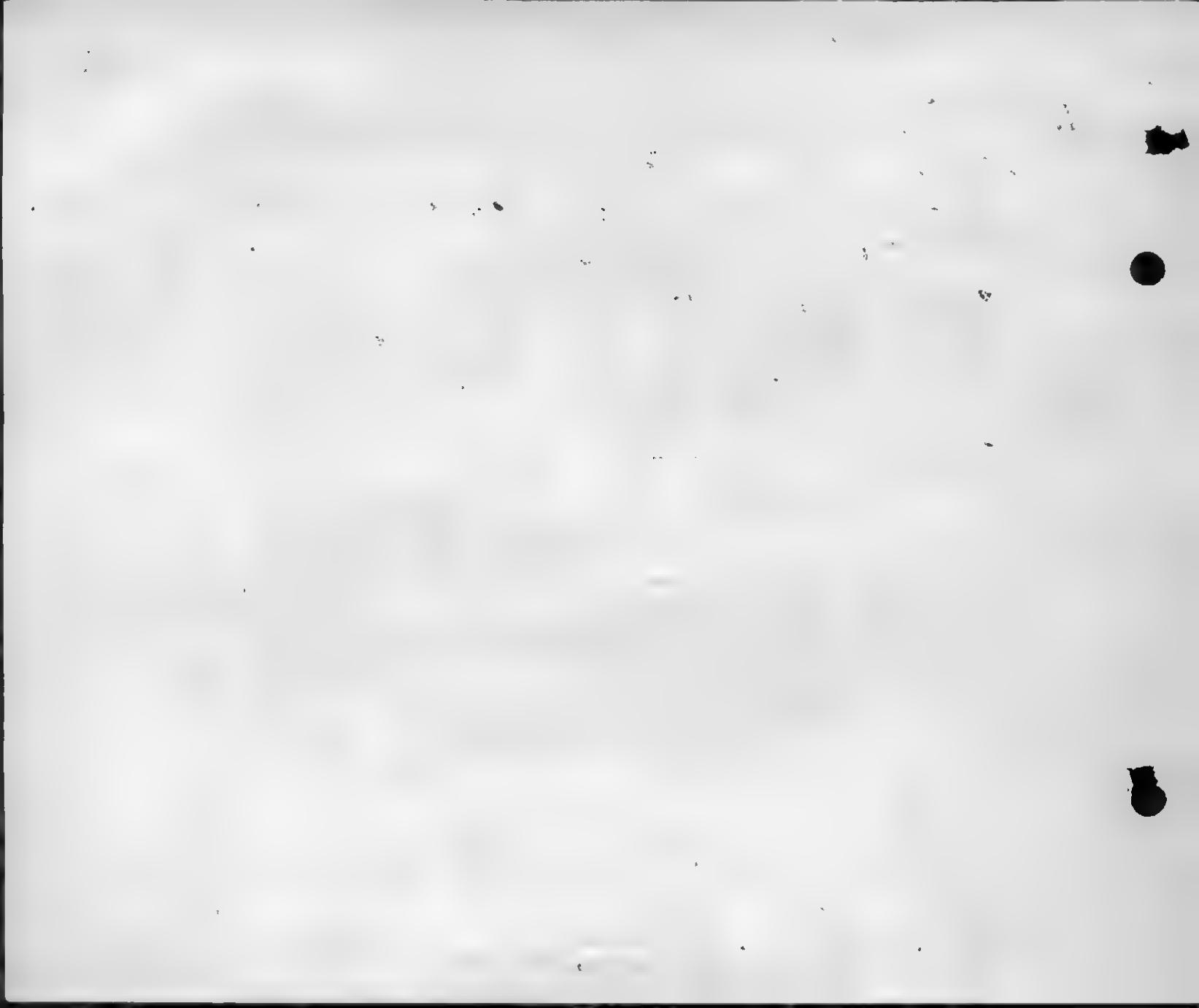
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06881

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)	
<i>Montgomery</i>		a. STATE <i>Washington DC.</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Arloma Park</i>		b. COUNTY	
c. LENGTH OF STAY IN 1b <i>6 days</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washingtonian San & Hosp</i>		d. STREET ADDRESS <i>6993 2nd St NW</i>	
e. NAME OF DECEASED (Type or print) <i>Dessie Kimball Basinger</i>		4. DATE OF DEATH <i>6 6 1961</i>	
f. SEX <i>Female</i>		5. COLOR OR RACE <i>White</i>	
6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH	
8. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) <i>67 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>	
13. FATHER'S NAME <i>Daniel Clodfelter</i>		14. MOTHER'S MAIDEN NAME <i>Elesia Sowers</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <i>No</i>		16. SOCIAL SECURITY NO. <i>579-01-7597</i>	
17. INFORMANT <i>Hosp record</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i>		DUE TO <i>Coronary Infarct Acute Postero-Lateral Wall</i>	
Conditions, if any, which gave rise to immediate cause (b) <i>Chronic Coronary Arterio-Sclerosis</i>		DUE TO <i>Coronary Infarct, old, multiple, Undetermined</i>	
Causing the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour _____ a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>JULY 1, 1961 to JUNE 6, 1961</i>	
(County) _____		(State) _____	
21. I certify that (I) (this hospital) attended the deceased from <i>June 6, 1961</i> and that death occurred at <i>PM</i> , from the causes and on the date stated above.		22a. SIGNATURE <i>George L. Ball</i>	
22c. PHYSICIAN'S NAME (Type) <i>George L. Ball</i>		22b. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6/19/61</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Cemetery</i>		23d. LOCATION (City, town or county) <i>Princes George's County, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Pumphrey Inc.</i>		25a. ADDRESS <i>8434 Georgia Avenue</i>	
RAYMOND A. 21810		25b. LOCATION (City, town or county) <i>Silver Spring, Maryland</i>	
25a. REC'D BY REGISTRAR <i>Princes George's County, Maryland</i>		25b. REGISTRAR'S SIGNATURE <i>Carla S. Kraus</i>	
DATE JUN 9 '61			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6895

CERTIFICATE OF DEATH

06882

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN lb

MARYLAND

20 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington Sanitarium & Hospital

e. NAME OF DECEASED (Type or print)

Ethel

First

Middle

Anita

f. SEX

F W

g. COLOR OR RACE

h. MARRIED NEVER MARRIED WIDOWED DIVORCED

i. DATE OF BIRTH

j. AGE (in years last birthday)

k. IF UNDER 1 YEAR Months Days

l. IF UNDER 24 HRS Hours Min.

m. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

n. KIND OF BUSINESS OR INDUSTRY

o. BIRTHPLACE, County & State, or foreign country

p. CITIZEN OF WHAT COUNTRY

q. FATHER'S NAME

Wellington Jackson

r. MOTHER'S MAIDEN NAME

Helen Jones

s. ADDRESS

t. INTERVAL BETWEEN ONSET AND DEATH

u. 3 hours

v. Sudden

w. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

x. PART I. DEATH WAS CAUSED BY:

y. IMMEDIATE CAUSE (a)

z. DUE TO

aa. Conditions, any, which

bb. gave rise to immediate cause

cc. stating the underlying

dd. cause last.

ee. DUE TO

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HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4 should be filed with the hospital or attending physician.

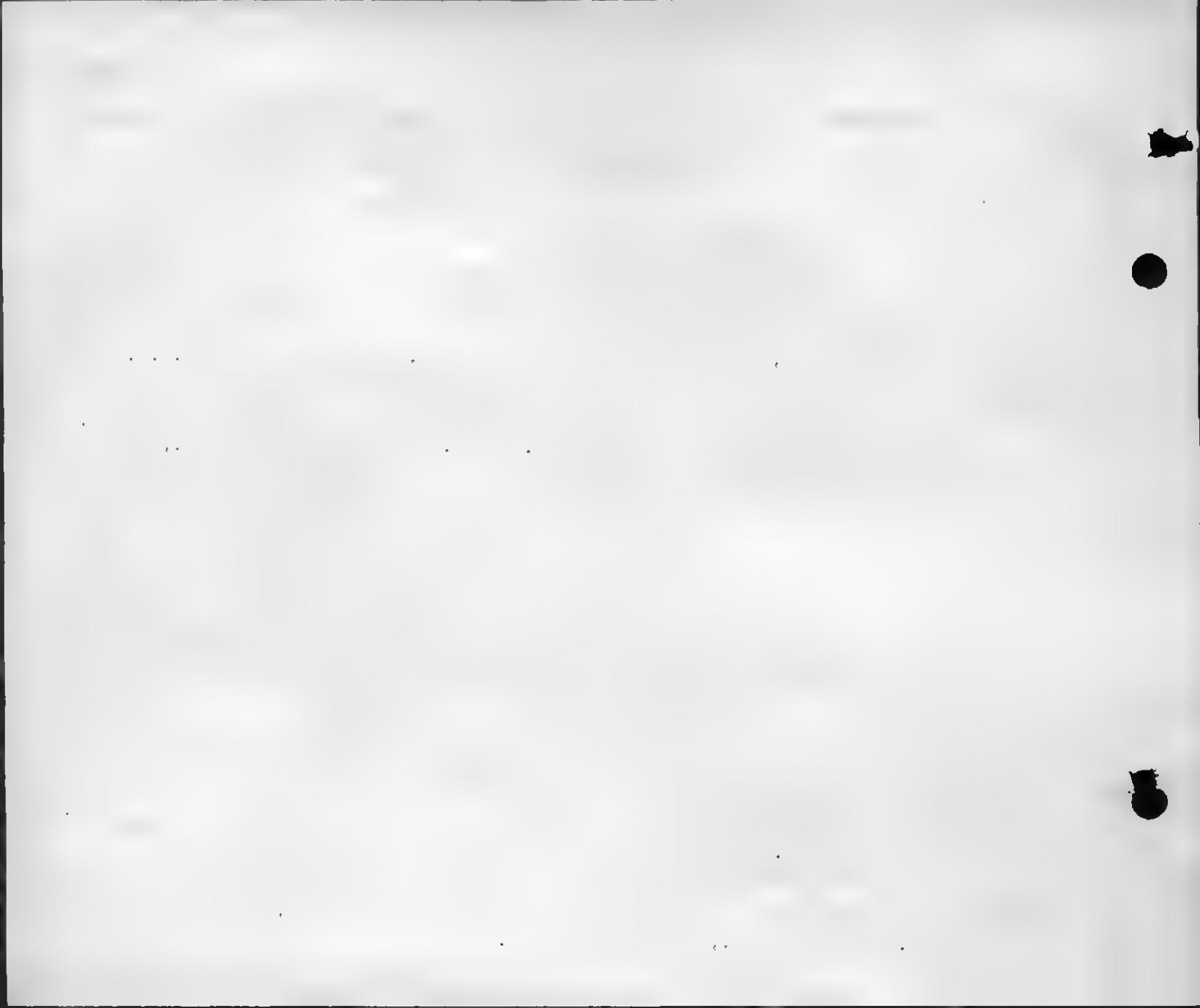
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6897

CERTIFICATE OF DEATH

06885

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1601 MYRTLE ROAD		d. STREET ADDRESS 1601 MYRTLE ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HESTER JENNIE BECKER		First	Middle
4. DATE OF DEATH JUNE 24 1961		Last	Month Day Year
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 11/29/1877		9. AGE (In years last birthday) IF UNDER 1 YEAR 85 yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HIGH SCHOOL TEACHER, retired		10b. KIND OF BUSINESS OR INDUSTRY TEACHING	
11. BIRTHPLACE (County & State, or foreign country) CARLISLE, NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DANIEL HUTTON		14. MOTHER'S MAIDEN NAME FELECIA FORBES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give rank or dates of service NO		16. SOCIAL SECURITY NO 076 03 5268	
17. INFORMANT NAT LOCATED		Address MRS. PAUL H. ROBBINS, 1601 MYRTLE RD., SILVER SPRING, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Acute antero-lateral coronary artery</i> <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>occlusion with myocardial infarction</i> DUE TO (c) <i>and congestive failure.</i>		INTERVAL BETWEEN ONSET AND DEATH 48 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. — p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>JUN 24</i> , 1961 to <i>JUN 24</i> , 1961, that (I) last saw the deceased alive on <i>JUN 24</i> , 1961, and that death occurred at <i>12:30</i> P.M. from the causes and on the date stated above.		22b. DATE SIGNED JUNE 24, 1961	
22a. SIGNATURE <i>Ernest E. Harmon</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <i>9301 Colesville Rd., Silver Spring, Md.</i>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) ERNEST E. HARMON		23d. LOCATION (City, town or county) (State) <i>CARLISLE, NEW YORK</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 6/27/1961	
23c. NAME OF CEMETERY OR CREMATORIAL CARLISLE CEMETERY		23d. LOCATION (City, town or county) (State) <i>CARLISLE, NEW YORK</i>	
24. FUNERAL DIRECTOR'S SIGNATURE PITNEY, INC. SILVER SPRING, MD.		25e. REC'D BY REGISTRAR DATE JUN 27 '61	
25b. REGISTRAR'S SIGNATURE <i>Anthony S. Koenig</i>			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 must be retained by the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6898

CERTIFICATE OF DEATH

66884

1. PLACE OF DEATH
a. COUNTY

Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda 2 days

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

First
Bengstrom

Middle

(Bengstrom)

E.

Bengstrom

4. SEX

6. COLOR OR RACE

make white

7. MARRIED NEVER MARRIED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if not now)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State or foreign country)

President Scientific Inst. Illinois

13. FATHER'S NAME

Charles A. Bengstrom

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.

(Yes, no, or unknown) (If yes give war or dates of service)

17. INFORMANT

Margaret E. Bengstrom same

18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last. }
} DUE TO
(b) }
} DUE TO
(c) }

Pulmonary edema

Myocardial infarction

INTERVAL BETWEEN
ONSET AND DEATH

3-4 days

MEDICAL CERTIFICATION

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Cerebral infarction, right parietal lobe

20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town)
p.m. While at work Not While at work factory, street, office bldg., etc.) (County) (State)

19

at work at work

21. I certify that (I) (this hospital) attended the deceased from July 1, 1955 to June 11, 1961, that (I) (we) last saw the deceased alive on June 11, 1961, and that death occurred at 5:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE John E. Everett

22c. PHYSICIAN'S NAME (Type) JOHN E. EVERETT

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE THEREOF 6/14/61

23c. NAME OF CEMETERY OR CREMATORIAL Memorial Park Cemetery Skokie, Illinois

23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06885

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE		Md		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Tahoma Park 4 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		7438 Baltimore		
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		Months Days Hours Min.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY		Germany		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO 155.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Reactive Cancer - (adenocarcinoma of Gall Bladder with metastasis.)		5 days		
(b)		DUE TO				symptom		
(c)		DUE TO				6 1/2 Mo		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED?		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____ alive on _____, and that death occurred at _____, from the causes and on the date stated above. ACTUAL SIGNATURE		1/24/1961		6/23/1961		ADDRESS (Street, city or town, state)		
PHYSICIAN'S NAME (Type)		Howard T. Morse		7030 Carroll Ave		DATE SIGNED 6/23/61		
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		
Burial		June 27, 1961		Fort Lincoln Cemetery		Prince George's County Md.		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
J. Arthur Walters, 254 Carroll St NW, D.C.				DATE JUN 27 '61		Curtis S. Frazer		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. It may be retained by the physician or attending physician after this certificate has been signed by the attending physician and completed. After this certificate has been signed by the attending physician and completed, it may be retained by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal; and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

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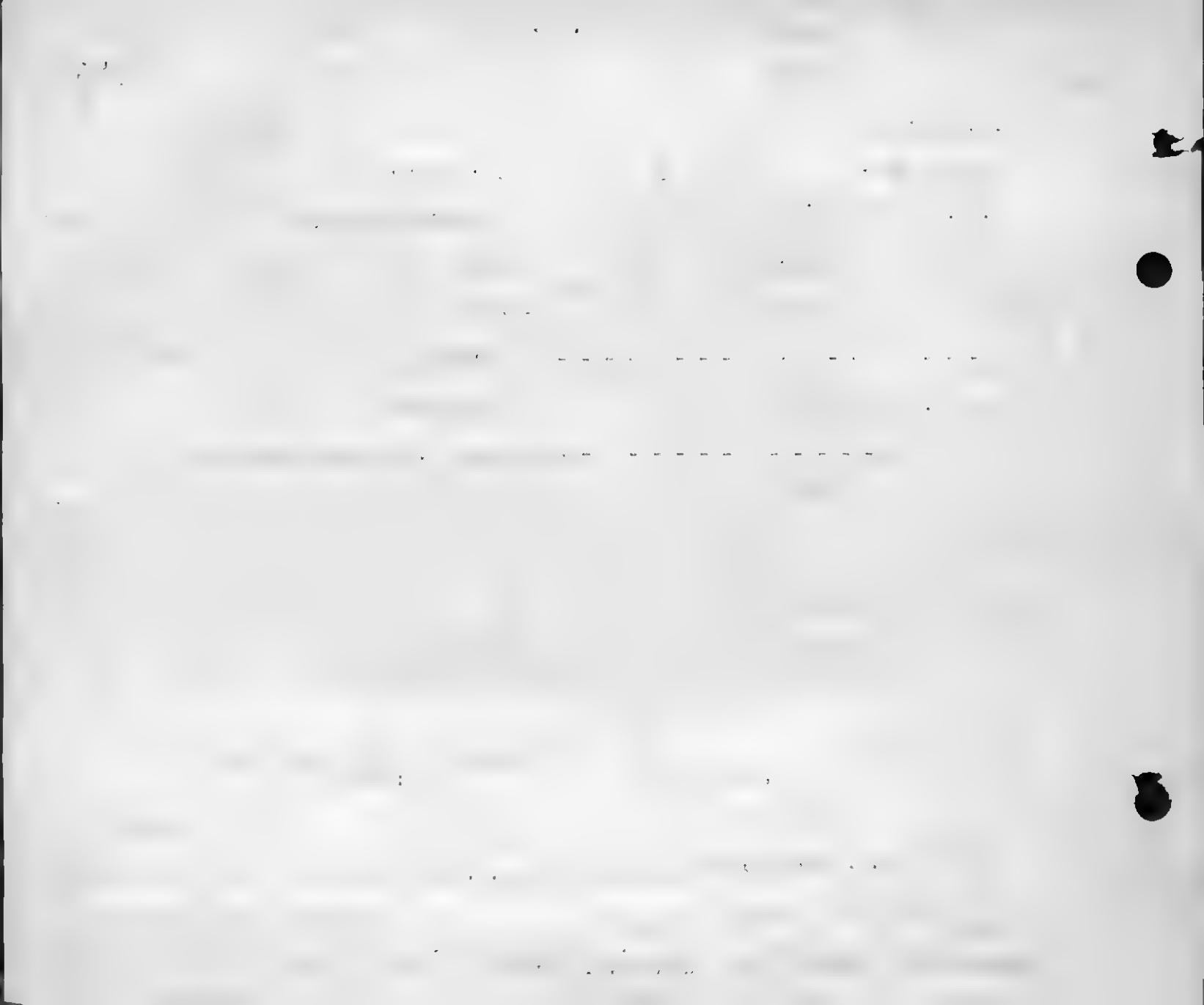
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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4 is to be filed with the State Dept. of Health.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

6200		06886	
1. PLACE OF DEATH a. COUNTY Montgomery <small>b. CITY OR TOWN (If outside corporate lim is, write RURAL and give nearest town)</small>		CERTIFICATE OF DEATH <small>MARYLAND</small> <small>c. LENGTH OF STAY IN lb</small> 10 days	
Bethesda (Rural) <small>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</small> U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)	
<small>a. STATE</small> Texas <small>c. CITY OR TOWN (If outside corporate lim is, write RURAL and give nearest town)</small> Nueces		<small>b. COUNTY</small> <small>e. IS RESIDENCE ON A FARM?</small> <small>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></small>	
<small>d. STREET ADDRESS</small> Corpus Christi		<small>8 X-X</small>	
<small>First</small> Byron		<small>Last</small> 241 Military Drive	
<small>Middle</small> Emory		<small>Month</small> June	
<small>5. SEX</small> Male		<small>Day</small> 23	
<small>6. COLOR OR RACE</small> Cauc		<small>Year</small> 19 61	
<small>7. MARRIED</small> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		<small>9. AGE (In years last birthday)</small> 8 yrs.	
<small>W.DOWED</small> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<small>IF UNDER 1 YEAR</small> <small>Months</small> 0 <small>Days</small> 0	
<small>10e. JSUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</small>		<small>10b. KIND OF BUSINESS OR INDUSTRY</small> II <small>BIRTHPLACE (County & State, or foreign country)</small> Virginia	
<small>13. FATHER'S NAME</small> Donald E. BOWLING		<small>12. CITIZEN OF WHAT COUNTRY?</small> USA	
<small>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give year or dates of service)</small>		<small>16. SOCIAL SECURITY NO.</small>	
<small>17. INFORMANT</small> No		<small>Address</small>	
<small>18. CAUSE OF DEATH</small> (Enter only one cause per line for (a), (b), and (c).)		<small>(F) Donald E. BOWLING Same as # 2 above</small>	
<small>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</small> <small>7540</small> <small>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</small>		<small>INTERVAL BETWEEN ONSET AND DEATH</small> <small>Congenital 18 years</small>	
<small>DUE TO (b)</small> <small>DUE TO (c)</small>		<small>Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</small>	
<small>20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</small>		<small>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</small>	
<small>20c. TIME OF INJURY</small> <small>Hour a.m. p.m.</small> <small>19</small>		<small>20d. INJURY OCCURRED</small> <small>Where at work <input type="checkbox"/> Not While at work <input type="checkbox"/></small>	
<small>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</small>		<small>20f. (City or town) (County) (State)</small>	
<small>21. I certify that (X) (this hospital) attended the deceased from 14 June 1961 to 23 June 1961, that (X) (we) last saw the deceased alive on 23 June 1961, and that death occurred at 6:30 PM on the causes and on the date stated above.</small>		<small>22b. DATE SIGNED</small> <small>6-24-61</small>	
<small>22e. SIGNATURE</small> <small>B.H. RICE LT, MC, USN</small>		<small>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/></small>	
<small>22c. PHYSICIAN'S NAME (Type)</small>		<small>22d. ADDRESS</small>	
<small>23e. BURIAL, CREMATION, 23b DATE THEREOF</small> <small>REMOVAL (Specify)</small> <small>Burial - Shipment 6-25-61</small>		<small>23c. NAME OF CEMETERY OR CREMATORIUM</small> <small>Woodlawn</small>	
<small>24. FUNERAL DIRECTOR'S SIGNATURE</small> <small>Tyson Wheeler</small>		<small>23d. LOCATION (City, town or county) (State)</small> <small>Bluefield, West Virginia</small>	
<small>ADDRESS</small> <small>1331 E. Montgomery Ave.</small>		<small>25e. REC'D BY REGISTRAR</small> <small>DATE JUN 27 '61</small>	
<small>Rockville, Maryland</small>		<small>25b. REGISTRAR'S SIGNATURE</small> <small>Arthur L. Krause</small>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11 Sept

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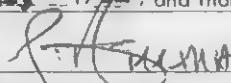
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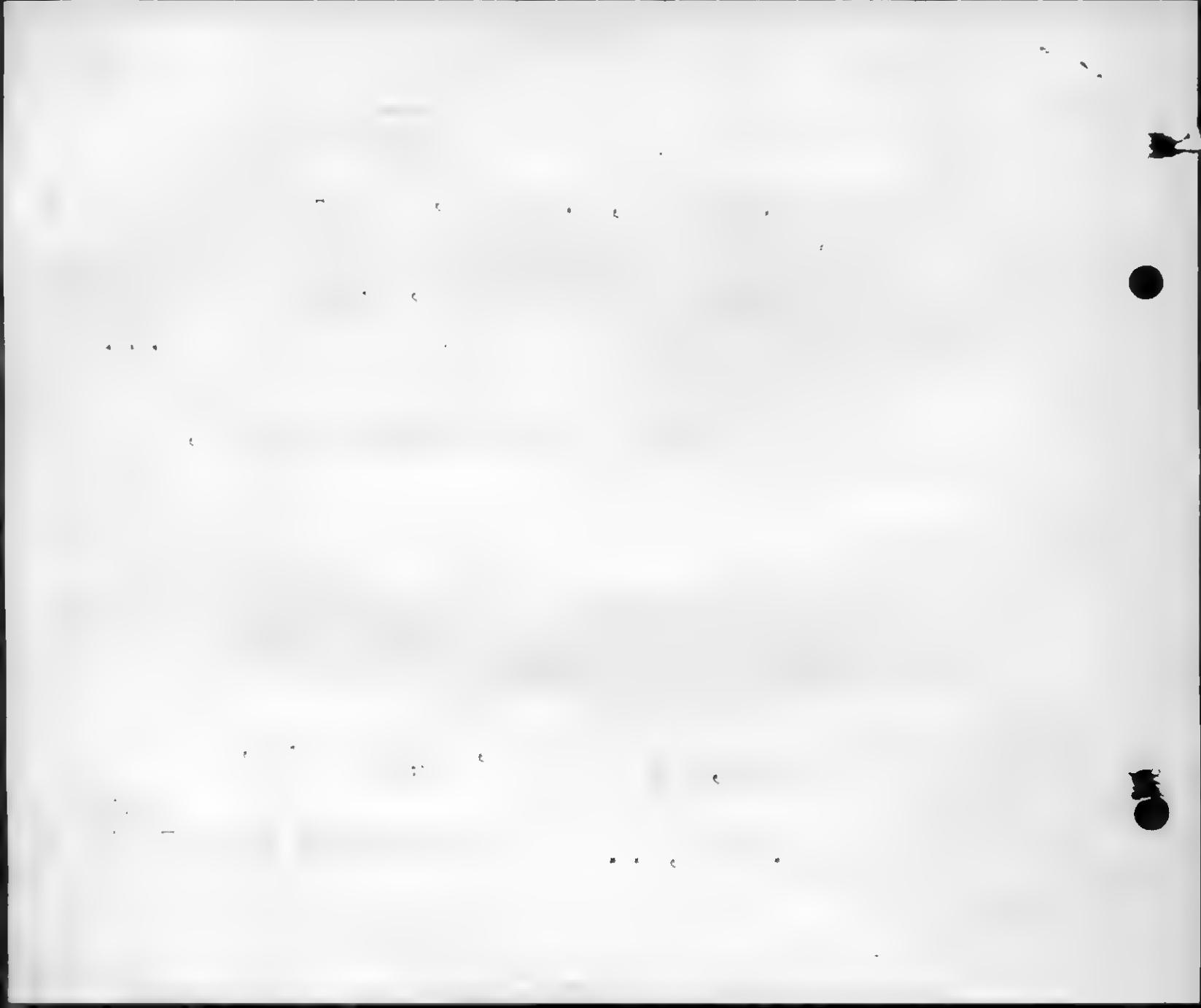
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06887

6901		ITEM 21 Film G269		6/23/61 ink	
1. PLACE OF DEATH a. COUNTY Montgomery		b. LENGTH OF STAY IN lb RURAL and give nearest town) Bethesda		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Tennessee	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cleveland		c. LENGTH OF STAY IN lb 17 Days		b. COUNTY Bradley	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route #4, Box 251 - B		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bryan		First Mark	Middle Brinkley	Last	4. DATE OF DEATH June 11,
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 30, 1959	
9. AGE (In years last birthday) 1 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		11. BIRTHPLACE (State or foreign country) Tennessee	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Bobbie Brinkley		14. MOTHER'S MAIDEN NAME Lois Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Records Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 3 mos.			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE LYMPHOCYTIC LEUKEMIA 204.3		DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO			
(c)		DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Cleveland		(County) Tenn.		(State) MD.	
21. I certify that (I) (this hospital) attended the deceased from May 25, 1961 , to June 11, 1961 , that (I) (we) last saw the deceased alive on June 11, 1961 , and that death occurred at 2:00PM from the causes and on the date stated above.					
22a. SIGNATURE 		22b. DATE SIGNED 6/11/61			
22c. PHYSICIAN'S NAME (Type) EMANUEL S. HELLMAN, M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
22d. ADDRESS The Clinical Center, Bethesda 14, National Institutes Of Health, Bethesda 14, Maryland		23a. BURIAL CREMATION REMOVAL <input type="checkbox"/> Burial-transit 6-12-61			
23b. DATE THEREOF 6-12-61		23c. NAME OF CEMETERY OR CREMATORIAL Moores Chapel Cemetery		23d. LOCATION (City, town, or county) Cleveland, Tenn.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE JUN 16 '61	
25b. REGISTRAR'S SIGNATURE 					



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TO HOSPITAL **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page _____ retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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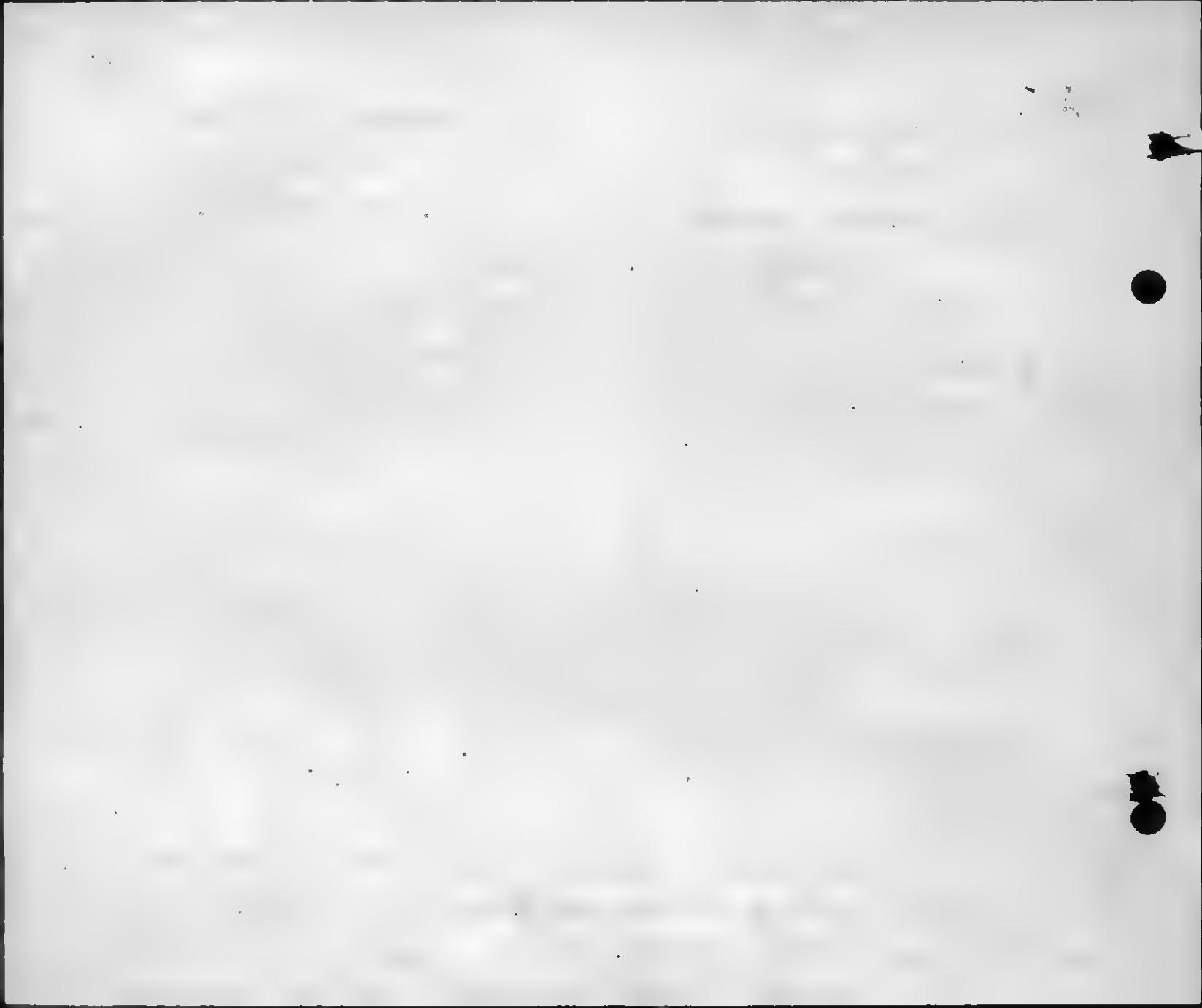
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6902

06888

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b Suburban Hospital		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital		d. STREET ADDRESS 500 W. Montgomery Ave.	
e. NAME OF DECEASED (Type or print) Josephine		e. DATE OF DEATH Last Month Day Year Brooks June 12, 1961	
f. SEX Female		g. COLOR OR RACE White	
h. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		i. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> May 6, 1880	
j. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		k. KIND OF BUSINESS OR INDUSTRY 11. IF UNDER 1 YEAR Months Days Hours Min. Connecticut	
l. FATHER'S NAME George H. Day		m. MOTHER'S MAIDEN NAME Katharine Beach	
n. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give rank or date of service) No		o. SOCIAL SECURITY NO. 17. INFORMANT None Martin Bennett-Son-3201 Burgundy Road	
p. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) IMMEDIATE CAUSE (b) IMMEDIATE CAUSE (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		q. INTERVAL BETWEEN ONSET AND DEATH 2 weeks Nephritis Arteriosclerosis generalized Unknown	
r. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Polyuria Bronchopneumonia		s. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
t. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		u. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
v. TIME OF INJURY Hour e.m. p.m. 19		w. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
x. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		y. (City or town) (County) (State)	
z. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from Sept. 1959 to May 12, 1961, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on May 11, 1961, and that death occurred at _____, from the causes and on the date stated above.		aa. DATE SIGNED 6/12/61	
bb. SIGNATURE George Sharpe		cc. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
dd. PHYSICIAN'S NAME (Type) George Sharpe		ee. ADDRESS 10511 Summit Ave. Kensington, Md.	
ff. BURIAL, CREMATION, DATE THEREOF REMOVAL (Specify) Cremation 6/13/61		gg. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory	
hh. LOCATION (City, town or county) Suitland, Maryland		ii. REC'D BY REGISTRAR DATE JUN 14 '61	
jj. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland		kk. REGISTRAR'S SIGNATURE Charles L. Kraus	



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Page _____ of _____

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. It may be retained by the hospital or attending physician and completely filled in by the funeral director.

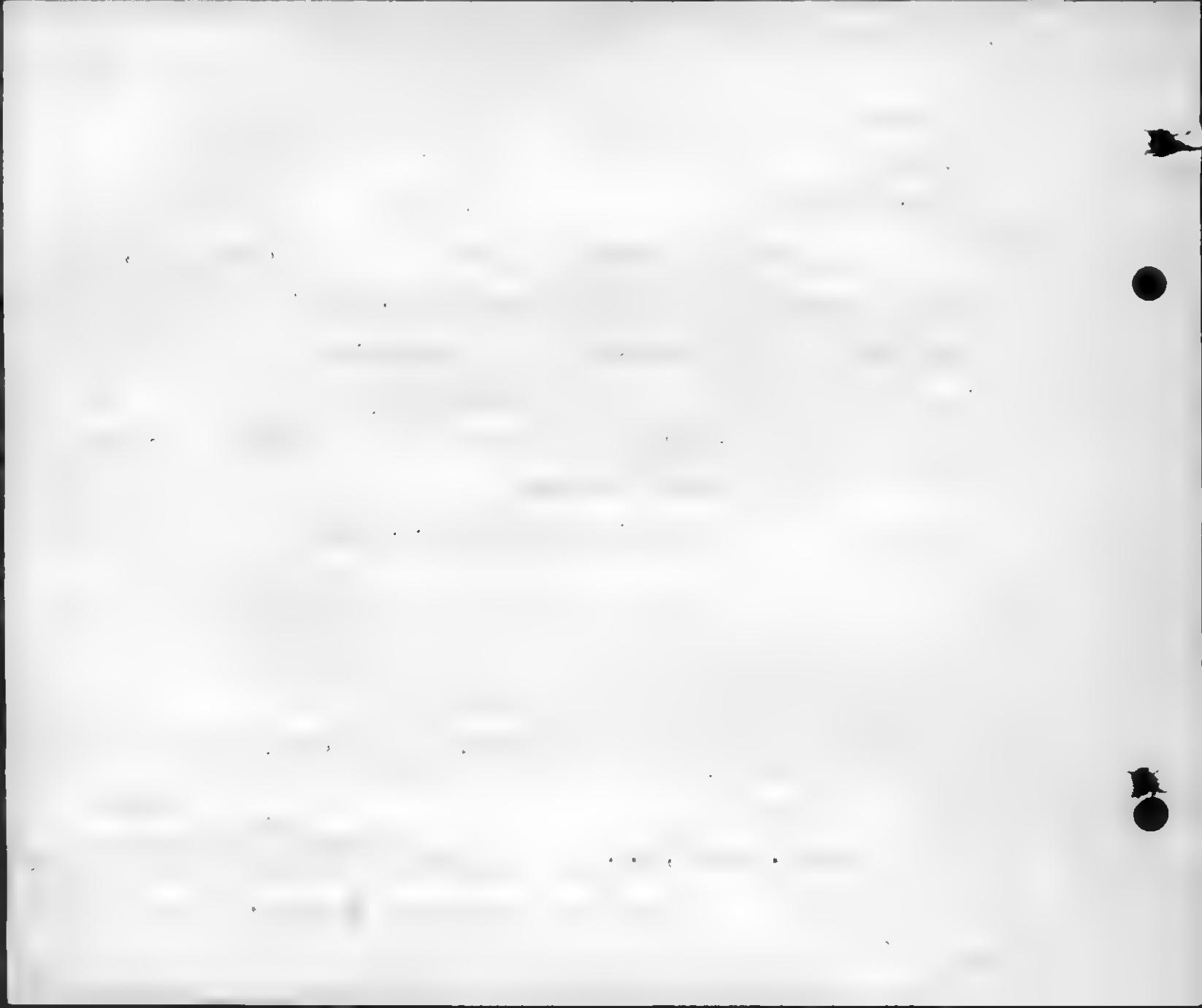
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06889

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE Pennsylvania		b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 16 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sarver							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				d. STREET ADDRESS R. D. # 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First RAY	Middle HENRY	Last BRYAN	4. DATE OF DEATH September 25, 1961	Month June	Day 9	Year 1961			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH September 25, 1913	9. AGF (In years last birthday) 47 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS					
			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		yrs.	Months	Days	Hours	Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY Medicine		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Cale Saylor				14. MOTHER'S MAIDEN NAME Pearl Bryan							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO unavailable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 16 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO Hypertensive Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH 11 years							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o m p m 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from May 24, 1961 to June 9, 1961 , that (we) last saw the deceased alive on June 9, 1961 and that death occurred at 8:00AM from the causes and on the date stated above.											
22a. SIGNATURE Thomas E. Gaffney				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>						22b. DATE SIGNED 6/9/61	
22c. PHYSICIAN'S NAME (Type) Thomas E. Gaffney, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland							
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 6/12/61		23c. NAME OF CEMETERY OR CREMATORIUM JARV ERSUNNE CEMETERY		23d. LOCATION (City, town, or county) BETHESDA TOWNSHIP P.Q.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Robert F. Humphrey - 7557 Wisconsin Ave.		ADDRESS F.H.		25a. REC'D. BY REGISTRAR JULY 12 '61		25b. REGISTRAR'S SIGNATURE Charles S. Thomas					



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FOR STATE
HEALTH DEPT.

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If any delay is necessary,
please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 4 to the funeral director. Page 5 may be retained for your files.

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TO DEPUTY
Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 4 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6904

06890

1. PLACE OF DEATH
COUNTY

Montgomery
b. C.TY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Takoma Park

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington Sanitarium and Hospital First Middle

3. NAME OF
DECEASED
(Type or print)

Dorothy

MARYLAND

c. LENGTH OF STAY IN 1b

DOA

Helen Budzianowski

4. DATE
OF
DEATH

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)

STATE

Maryland

b. COUNTY

Prince George

c. C.TY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Lewisdale

d. STREET ADDRESS

1657-2

e. IS RESIDENCE
ON A FARM?
YES NO

Year

5. SEX

Female

6. COLOR OF RACE

White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

Last

Month

Day

Year

1961

9. AGE (In years
last birthday)

45 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

13. FATHER'S NAME

Roger Crowley

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) If yes give war or date of service

yes Navy - P42-47

16. SOCIAL SECURITY NO.

17. INFORMANT

Mary O'Malley

Address

Washington Sanitarium & Hospital Records

INTERVAL BETWEEN
ONSET AND DEATH

420. PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Conditions, if any, which
gave rise to immediate cause

(a), stating the underlying
cause last.

420. DUE TO

(b)

DUE TO

(c)

420. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.
p.m.

19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

FRANK J. Borschelt

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

6-5-61

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial June 7, 1961

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

Arlington National Cemetery

22d. LOCATION (City, town, or county)

Arlington, Va.

(State)

23. FUNERAL DIRECTOR

J. K. Funeral Home, 254 Carroll St. N.W. Wash. D.C.

ADDRESS

24a. REC'D BY REGISTRAR

JUN 7 '61

24b. REGISTRAR'S SIGNATURE

Carroll S. Kraus

DATE



TO HOSPITAL **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6905

60891

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN 1B

MARYLAND

21 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington Sanitarium and Hospital 15 1/2 Belmont Lane

First

Middle

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

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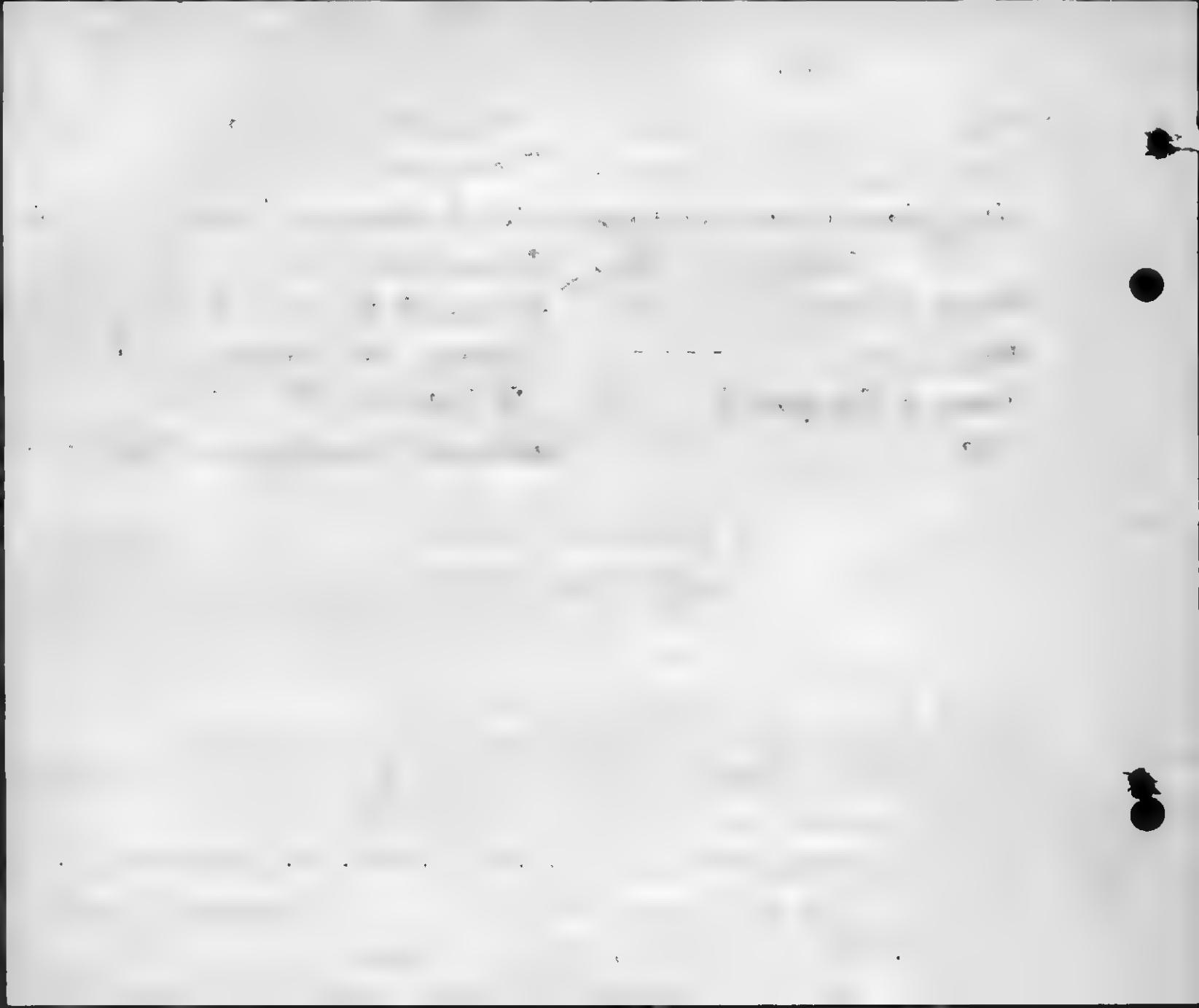
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FOR STATE
HEALTH DEPT.

If any delay is necessary,
please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 20-21 Film 289 6-27-61 a.m. MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6906 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06892

1. PLACE OF DEATH Items 14 & 13 B115 Film 288 6-27-61
a. COUNTY Montgomery MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park MD. O.A.

c. LENGTH OF STAY IN IB

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wash. Stn + Hosp.

2. USUAL RESIDENCE (where deceased lived, if institution, Residence before admission)
a. STATE Maryland b. COUNTY Montgomery

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring

d. STREET ADDRESS 19511 Pin Oak Ave

e. IS RESIDENCE ON A FARM? YES NO

3. NAME OF DECEASED First Richard Middle Earl Last Carson

4. DATE OF DEATH Month 6 Day 13 Year 1961

5. SEX M 6. COLOR OR RACE W 7. MARRIED NEVER MARRIED
WIDOWED DIVORCED

8. DATE OF BIRTH 1-13-92 9. AGE (in years if under 1 year
last birthday) 69 yrs. IF UNDER 24 HRS
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mgr

10b. KIND OF BUSINESS OR INDUSTRY Sinclair Oil

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Thomas Edward Carson

14. MOTHER'S MAIDEN NAME Tirzah L. Donaldson Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes 16. SOCIAL SECURITY NO. 17. INFORMANT
(Yes, no, or unknown) (If yes, see www.gordonserv.ca) 216-05-2567 MRS. Richard Carson Jr.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MULTIPLE FRACTURES OF THE SKULL

DUE TO
(b) MYOCARDIAL INFARCTION WITH CARDIAC ENLARGEMENT AND CONGESTIVE FAILURE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO
(c) MARKEDLY SEVERE CORONARY ARTERIOSCLEROYSIS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES NO

20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
Cause of Death. was leaving house to water flowers, when he fell down steps

20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While at work Not While at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
7:30 p.m. 6-13-61 home Silver Spring Montg Md

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry , and in my opinion death resulted from. Natural causes Accident Suicide Homicide Undetermined manner

MEDICAL CERTIFICATION

ACTUAL SIGNATURE Frank J. Broschart CHIEF MEDICAL EXAMINER
EXAMINER'S NAME (Type) FRANK J. BROSCRAFT ASSISTANT MEDICAL EXAMINER
DATE SIGNED 6-14-61

22a. BURIAL, Cremation or Removal 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS (Street, city, town, or county) 22d. LOCATION (City, town, or country) (State)
burial 6/16/61 Arlington Nat. Cemetery Arlington, Virginia

23. FUNERAL DIRECTOR ADDRESS Wash, D.C. 24a. REG'D BY REGISTRAR JUN 15 '61 24b. REGISTRAR'S SIGNATURE
The S.H. Hines Co., 2901 14th St. N.W. DATE Arthur S. Thorne



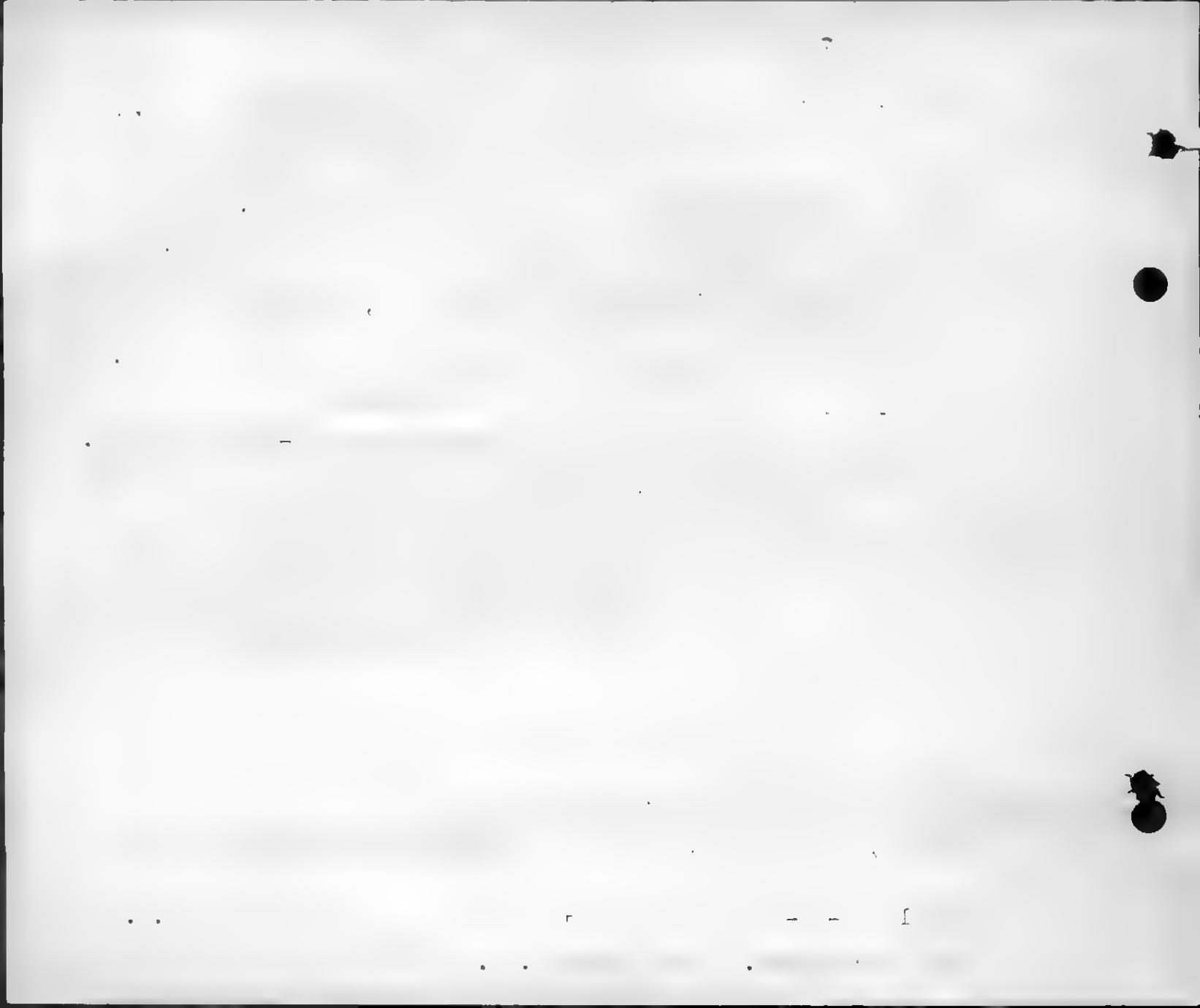
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

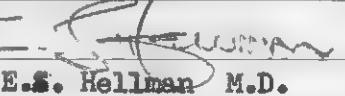
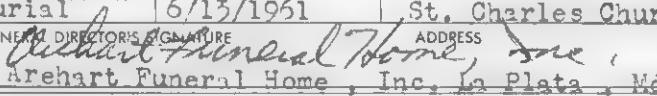
CERTIFICATE OF DEATH

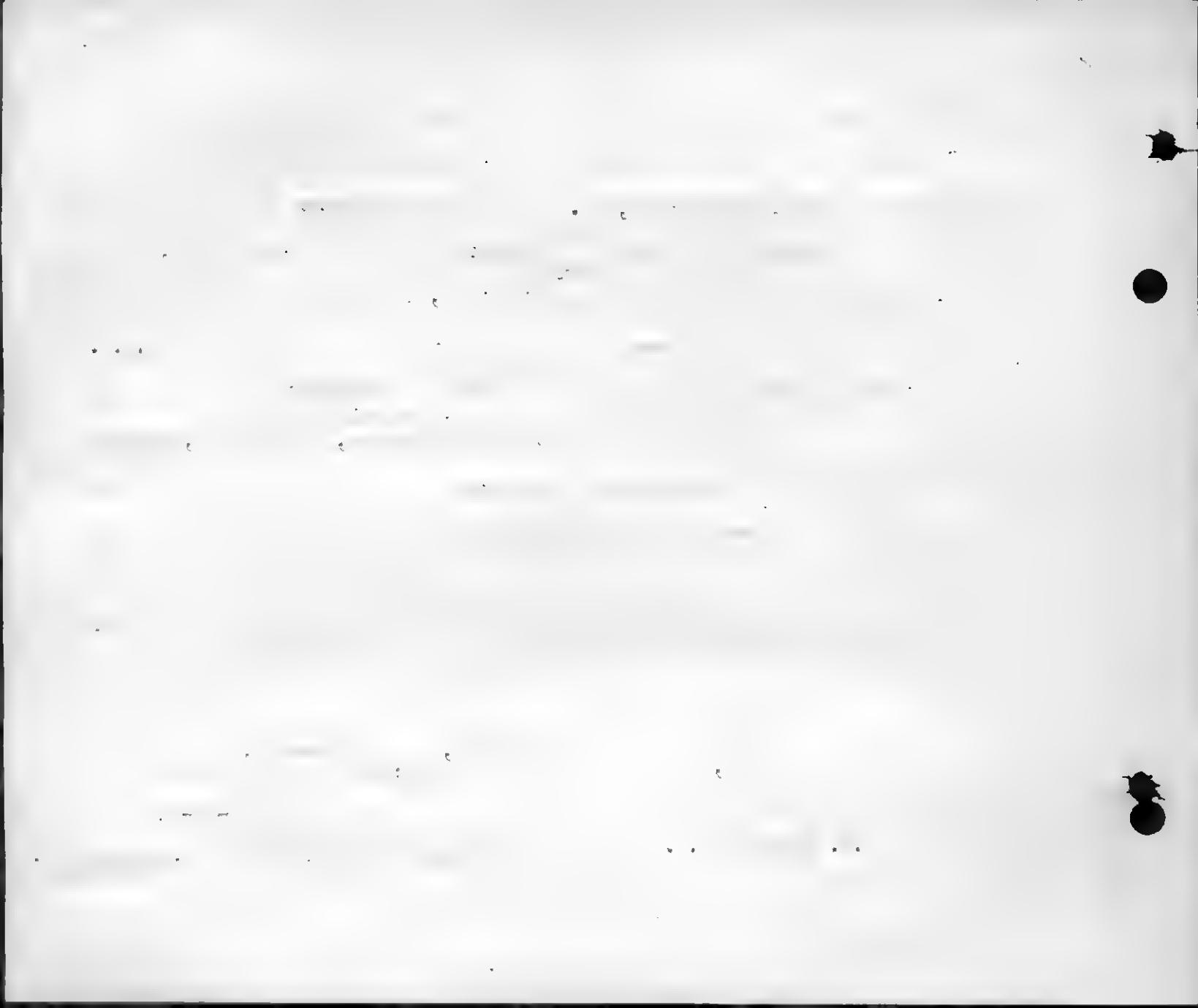
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1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE Maryland		b. COUNTY Pr George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. LENGTH OF STAY IN 1b 1 1/2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs		d. STREET ADDRESS 6116 Westchester Dr.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Bardens Sanitarium						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Mary	Middle Josephine	Last Casson	4. DATE OF DEATH June	Month 8	Day 19	Year 61
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 20, 1864		9. AGE (In years last birthday) 96^{rs}	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Wood		14. MOTHER'S MAREN NAME Unknown				Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Edna Naughton - same as above.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 4 days								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		DUE TO (b)		Coronary Artery Disease,				
		DUE TO (c)		Heart Block				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Month, Day Year Hour a.m. p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19								
21. I certify that (I) (this hospital) attended the deceased from Dec. 1969 to June 8, 1961, that (I) (we) last saw the deceased alive on June 6, 1961, and that death occurred at 9:10 P.M. from the causes and on the date stated above								
22a. SIGNATURE <i>Robert T. Thibadeau</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED June 8, 1961				
22c. PHYSICIAN'S NAME Robert T. Thibadeau, M.D.		22d. ADDRESS 10609 Concord St., Kensington, Md.						
23a. BURIAL, CREMAT.ON. REMOVAL (Specify) Burial		23b. DATE THEREOF 6-12-61		23c. NAME OF CEMETERY OR CREMATORIUM Mt Olivet		23d. LOCATION (City, town, or county) Washington D.C.		
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home.		ADDRESS Washington D. C.		25a. REC'D BY REGISTRAR JUN 13 '61		25b. REGISTRAR'S SIGNATURE Charles L. Kraus		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after the death. If the physician or attending physician may be retained by the hospital or attending physician, this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										06894					
CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 43 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.					2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) d. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head d. STREET ADDRESS 110 Circle Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) Melanie First Melanie Middle Gay Last Cather				4. DATE OF DEATH June 10, 19 61											
5. SEX Female White		6. COLOR OR RACE White WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH August 12, 1955		9. AGE (In years last birthday) 5 yrs. Months Dots Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Cather					14. MOTHER'S MAIDEN NAME Patricia Sutherland										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Records The Clinical Center, Bethesda 14, Maryland											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Lymphatic Leukemia DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 4 Days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from April 29, 1961, to June 10, 1961 , that (I) (we) last saw the deceased alive on June 10, 1961 , and that death occurred at 11:50 AM from the causes and on the date stated above.															
22a. SIGNATURE 					M.D. ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 6-11-61					22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) E.S. Hellman M.D.					22d. ADDRESS The Clinical Center National Institutes Of Health, Bethesda 14, Maryland										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/13/1961		23c. NAME OF CEMETERY OR CREMATORIAL St. Charles Church Cemetery			23d. LOCATION (City, town, or county) Glymont, Maryland								
24. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS Arshart Funeral Home, Inc., La Plata, Md.		25a. REC'D BY REGISTRAR JUN 16 '61			25b. REGISTRAR'S SIGNATURE 								
VR A15 (4) 15M 9/59															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed on 24 hours after a patient may be retained in hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

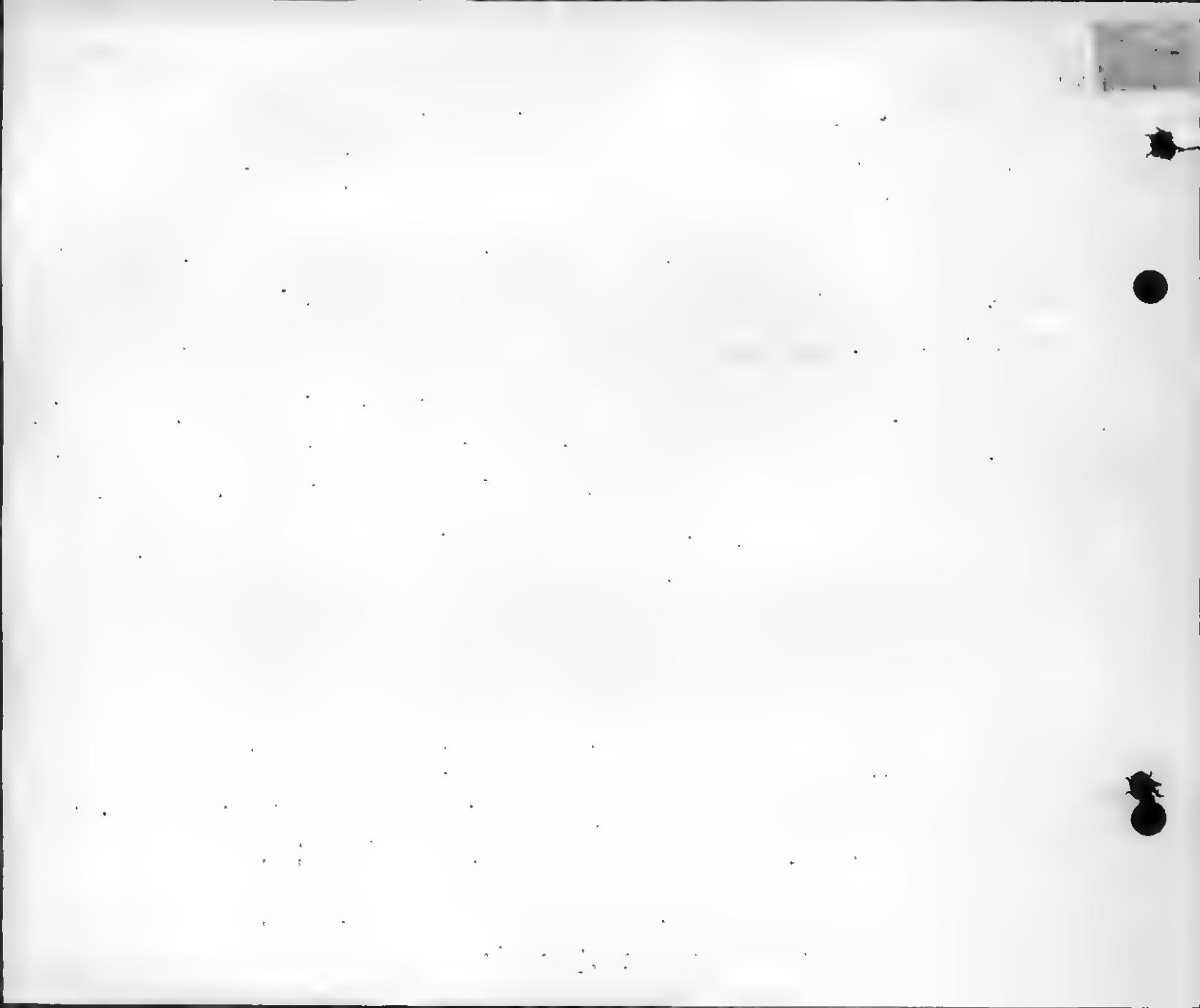
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15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6910

CERTIFICATE OF DEATH

Reg. Dist. No. 06897

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		21. USUAL RESIDENCE (Where deceased lived if institutional Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Colesville</i>		b. COUNTY <i>Montgomery</i>	
c. LENGTH OF STAY IN 1b <i>1 month</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring, Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Mary Lee Rest Home</i>		d. STREET ADDRESS <i>Silver Spring, Md.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>John</i>	Middle <i>C.</i>	Last <i>Cissel</i>
4. DATE OF DEATH	Month <i>June</i>	Day <i>27</i>	Year <i>1961</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/10/76</i>
9. AGE (In years last birthday) <i>85</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Cabinet maker</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME <i>Wilbur F. Cissel</i>	14. MOTHER'S MAIDEN NAME <i>Clara Brown</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO <i>214-03-8668</i>	INFORMANT <i>Dorothy Lehmkull</i>	ADDRESS <i>109 Belvoir Rd Silver Spring Md</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>33IX</i>		<i>Seizure Vasovagal Accident</i> <i>4 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Generalized Convulsive Seizure</i>		<i>Generalized Convulsive Seizure</i> <i>years</i>	
(c) DUE TO <i>—</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>None</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II if item 18.) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Feb. 1, 1961</i> to <i>June 27, 1961</i> that I last saw the deceased alive on <i>June 26, 1961</i> , and that death occurred at <i>6 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>1919 Seminary Rd., Silver Spring, Md.</i> DATE SIGNED <i>John S. Rogers M.D. 1919 Seminary Rd. - 6-27-61</i>	
ACTUAL SIGNATURE <i>John S. Rogers</i>		PHYSICIAN'S NAME (Type) <i>John S. Rogers</i> 1919 Seminary Rd., Silver Spring, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6/29/61</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Marks</i>	22d. LOCATION (City, town, or county) <i>Highland, Maryland</i> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Md.</i>		24a. REC'D BY REGISTRAR ADDRESS <i>JUN 30 '61</i>	24b. REGISTRAR'S SIGNATURE <i>John S. Rogers</i>



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page _____ retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6909 66895

CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN lb

DOB

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Suburban Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If out'side corporate limits, write RURAL and g.v.e nearest town)

15 Wheaton Woods (Rockville)

d. STREET ADDRESS

4414 Ires Street

Last

4

Month

8

Day

Year

4. DATE
OF
DEATH

June

9. AGE (In years
last birthday)

IF UNDER 1 YEAR

yrs.

3

Months

22

Days

IF UNDER 24 HRS.

Hours

Min.

5. SEX

6. COLOR OR RACE

Male White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

February 17, 1961

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Thomas Melvin Chilcott

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

16. SOCIAL SECURITY NO.

17. INFORMANT

(Yes, no, or unknown) (If yes give rank or dates of service)

— (Father) Thomas Chilcott (same as above)

Address

INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH [Enter only one cause per line for (e), (b) and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (e)

491X DUE TO

Conditions, if any, which
gave rise to immediate cause

} (b)

gave rise to immediate cause

} (a), stating the underlying
cause last.

DUE TO

cause last.

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e).

Patient had two arterioles.

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

20d. INJURY OCCURRED

While at work

Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from.....

saw the deceased alive on.....

and that death occurred at

22a. SIGNATURE

Carl Silverman

22c. PHYSICIAN'S
NAME (Type)

Carl Silverman

23b. DATE THEREOF

REMOVAL (Specify)

Burial June 9, 1961

23c. NAME OF CEMETERY OR CREMATORIAL

Gate of Heaven Cemetery

ADDRESS

Warren E. Pumphrey, Inc., 8434 Georgia Ave.,

Silver Spring, Md.

25a. REC'D BY REGISTRAR

Raymond A. Zyska

JUN 12 '61

DATE

ADDRESS

Montgomery County, Md.

REGISTRAR'S SIGNATURE

Carl Silverman

JUN 12 '61

DATE

ADDRESS

Montgomery County, Md.

REGISTRAR'S SIGNATURE

Carl Silverman

JUN 12 '61

DATE

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ADDRESS

Montgomery County, Md.

REGISTRAR'S SIGNATURE

Carl Silverman

JUN 12 '61

DATE

ADDRESS

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Carl Silverman

JUN 12 '61



TO HOSPITAL **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6911

CERTIFICATE OF DEATH

66898

1. PLACE OF DEATH

a. COUNTY
MONTGOMERY

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

ROCKVILLE

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

1213 BROADWOOD DRIVE

MARYLAND

c. LENGTH OF STAY IN hb

2 weeks

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE
MARYLAND

b. COUNTY
MONTGOMERY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

ROCKVILLE

d. STREET ADDRESS

1213 BROADWOOD DRIVE

e. IS RESIDENCE ON A FARM?

YES NO

3. NAME OF
DECEASED
(Type or print)

First
ELIZABETH

Middle

Last
CLISER

DATE
OF
DEATH

Month
JUNE
Day
2
Year
19 61

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED DIVORCED

OCT 6, 1894

9. AGE (in years
last birthday)
66 yrs.

IF UNDER 1 YEAR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOMEMAKER

10b. KIND OF BUSINESS OR INDUSTRY

OWN HOME

11. BIRTHPLACE (County & State, or foregn country)

PAGE CO. VIRGINIA

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

WILLIAM JEWELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)

NO

16. SOCIAL SECURITY NO. | 17. INFORMANT

Mr. Oliver J. Cliser

1213 Broadwood Dr.
Rockville Md.

INTERVAL BETWEEN
ONSET AND DEATH

2 days -
6 mos

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Pulmonary edema

Carcinoma stomach
with metastases

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING []
OR CONTRIBUTING [] CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While at work
p.m. 19 Not While at work at work

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 1/5/61, 19, to 6/2/61, 19, that (I) (we) last saw the deceased alive on 6/2/61, 19, and that death occurred at 10 A.M. from the causes and on the date stated above.

22a. SIGNATURE

Patrick Jameson M.D.

22c. PHYSICIAN'S
NAME (Type) Patrick C. Jameson

22b. DATE
SIGNED

6/2/61

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

June 7, 1961

23c. NAME OF CEMETERY OR CREMATORIUM

Fort Lincoln Cemetery

23d. LOCATION (City, town or county)

Prince George County Md.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Warren E. Pumphrey, Inc.
Raymond A. Ziska

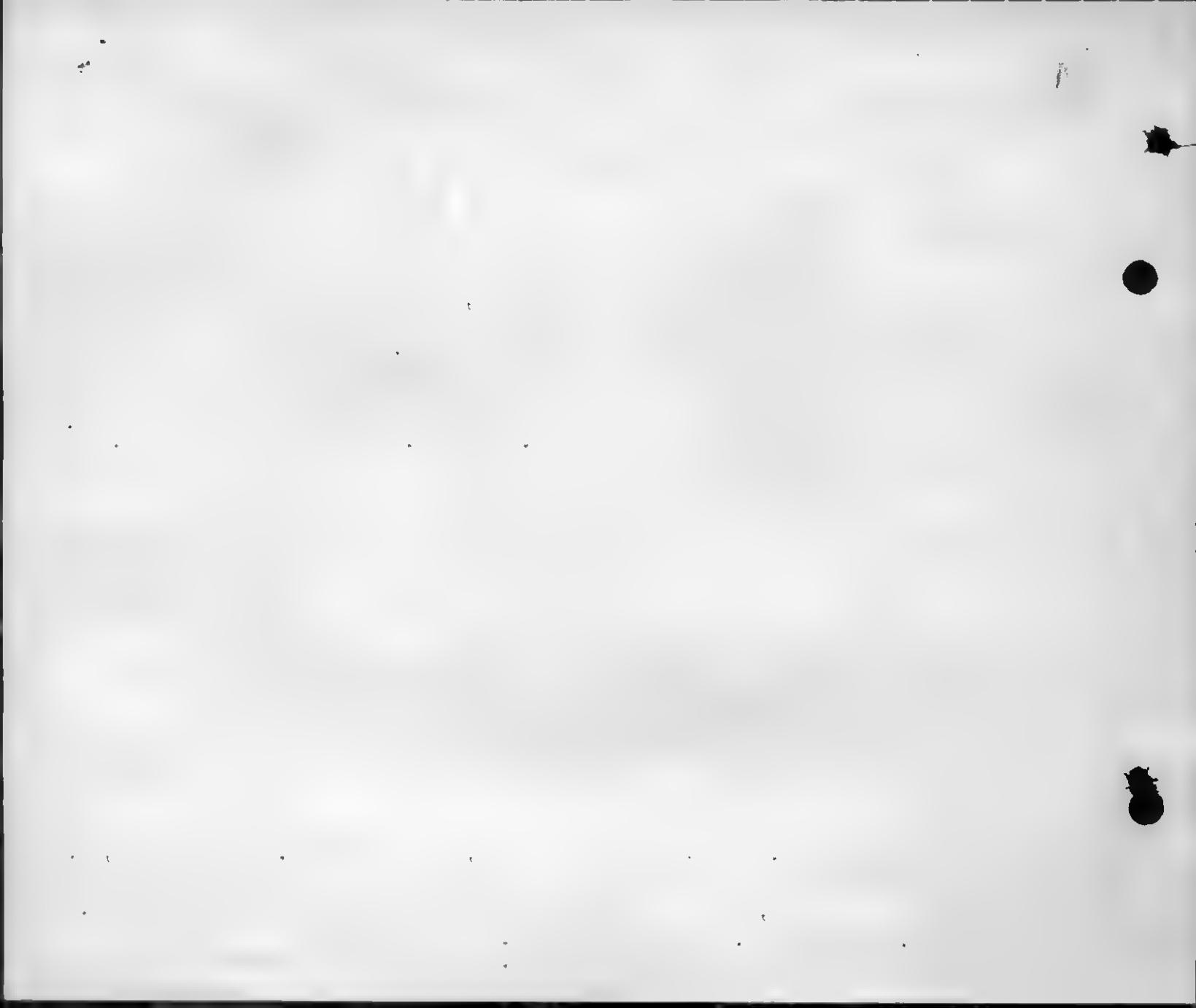
ADDRESS

8434 Georgia Ave.
Silver Spring Md.

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

JUN 9 '61

Arthur S. Knapp



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after the deceased may be received in hospital or attending physician. After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

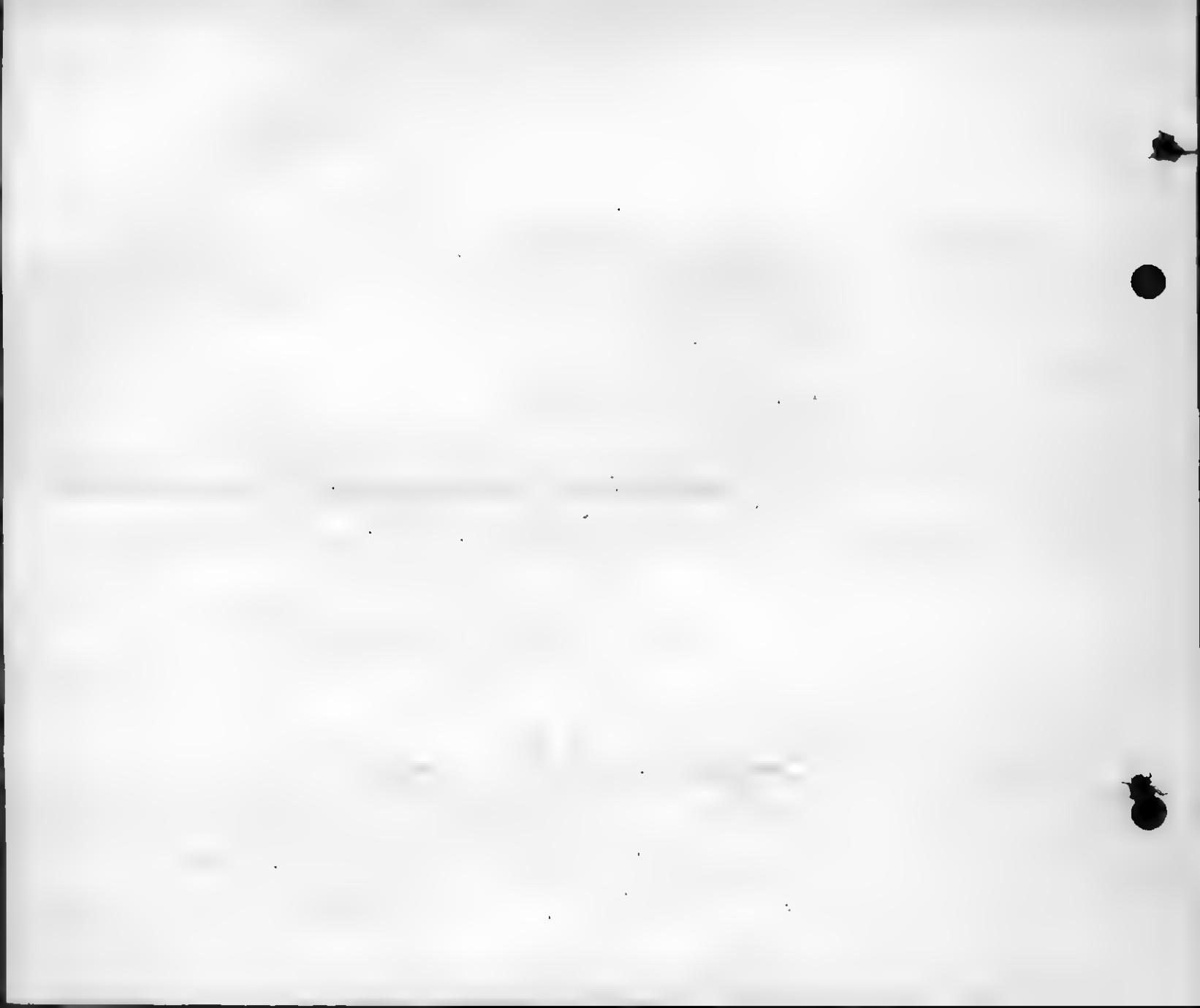
CERTIFICATE OF DEATH

M		0912		06899	
1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
Montgomery Maryland		Rural, Landover		47 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. LENGTH OF STAY IN lb		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Gartling Nursing Home					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
Albert Valentine				Cobb	Month Day Year 6/11/1961
SEX		5. COLOR OR RACE	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH	8. AGE (In years last birthday) yrs
Male		White		Apr 2, 1880	81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Farmer		Farming		Windsor N.C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Albert Valentine Cobb		Margaret Sharrock		U.S.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Name: Mrs. L. Gochowar. Address: 1015 Elm Ave. Relation: Daughter of deceased. Tabitha Park Md.	
No		None			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH			
4 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		3 days			
(b) DUE TO		Brucellosis pneumonia			
(c) DUE TO		Gen. catarrhalis. Senile dementia. 2 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour a.m. p.m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19				1961, to 6/11, 1961	
21. I certify that (I) (this hospital) attended the deceased from _____ saw the deceased alive on _____, and that death occurred at _____ M. from the causes and on the date stated above.					
22a. SIGNATURE		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE 6/11/61	
H. T. Morse		22d. ADDRESS 7030 Carroll Ave, Tabitha Park, Md.			
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL Edgewood Cemetery	
Burial		June 14, 1961			
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR DATE JUN 13 '61	
J. Arthur Waite, 254 Carroll St. N.W. DC				25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after the deceased has been admitted to a hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH				06900							
6913				Item 9 from 0290 1/10/61 iwk							
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN lb <u>6 mos.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u> d. STREET ADDRESS <u>7714 Evans Lane</u>							
3. NAME OF DECEASED (Type or print) <u>Manuel Comulada</u>				4. DATE OF DEATH <u>6 22 1961</u>							
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-17-86</u>		9. AGE (In years at birth) <u>75/88 yrs</u>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ARMED FORCES</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>				11. BIRTHPLACE (State or foreign country) <u>BRTA Rica</u>			
13. FATHER'S NAME <u>John Comulada</u>				14. MOTHER'S MAIDEN NAME <u>CARMAN Ortiz</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>				16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT <u> </u> Address <u> </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerosis Generalized</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 19 60</u> to <u>June 22 1961</u> that (I) (we) last saw the deceased alive on <u>20 Jun 1961</u> and that death occurred at <u>11 AM</u> , from the causes and on the date stated above											
22a. SIGNATURE <u>B.C. Merkle, M.D.</u>				M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED <u> </u>			
22c. PHYSICIAN'S NAME (Type) <u>B.C. Merkle, M.D.</u>				22d. ADDRESS <u>WALTER REED Hosp.</u>							
23a. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>6-26-61</u>				23c. NAME OF CEMETERY OR CREMATORIAL FACILITY <u>Arlington Natl Cem Arlington Va</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>J.W. Jackson 300-4th St. N.E. WASH. 2, D.C.</u>				ADDRESS <u> </u>				25a. REC'D BY REGISTRAR <u> </u> DATE <u>JUN 26 '61</u>			
								25b. REGISTRAR'S SIGNATURE <u> </u>			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda (Rural)

c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

U. S. Naval Hospital

3. NAME OF DECEASED

(Type or print)

First

Middle

Ethel

Gertrude

5. SEX

Female

6. COLOR OR RACE

Caucasian

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

John K. BLACKWELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or grade of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

(S) Eugene G. Condyle, same as #2 above

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

Renal shutdown with secondary carcinoma of the cervix

INTERVAL BETWEEN ONSET AND DEATH

2 yrs

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (this hospital) attended the deceased from April 24, 1961 to June 22, 1961, that (we) last saw the deceased alive on June 22, 1961, and that death occurred at 3:20AM M, from the causes and on the date stated above.

22a. SIGNATURE

Arthur O. Anctil, Jr., MC, LT, USN

M.D. ATTENDING PHYS.

MED. DIRECTOR STAFF PHYS.

22b. DATE SIGNED
6-22-61

22c. PHYSICIAN'S NAME (Type)

Arthur O. ANCTIL, JR., MC, LT, USN U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

6-24-61

23c. NAME OF CEMETERY OR CREMATORIUM

Riverview Cemetery

23d. LOCATION (City, town or county) (State)

Richmond

Virginia

24. FUNERAL DIRECTOR'S SIGNATURE

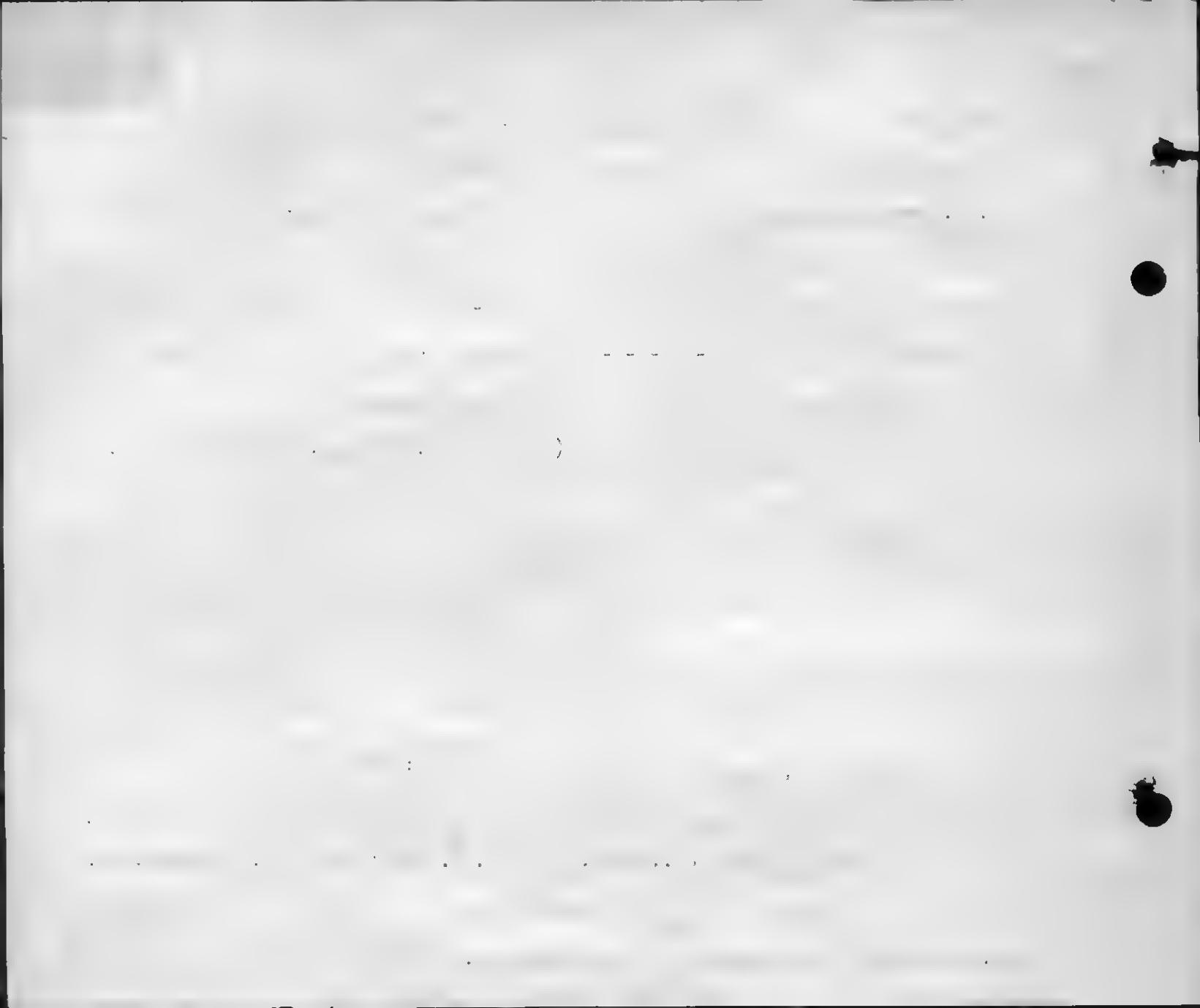
Jos. W. Bliley, 3rd & Marshall Sts., Richmond, Va.

25a. REC'D BY REGISTRAR

JUN 26 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Kincaid



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6915

CERTIFICATE OF DEATH

06902

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

1. PLACE OF DEATH

e. COUNTY
Montgomeryb. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural)d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
U. S. Naval Hospital

MARYLAND

c. LENGTH OF STAY IN HOSPITAL

44 days

3. NAME OF DECEASED (Type or print)

First

Middle

Mamie

5. SEX

Female

6. COLOR OR RACE

Caucasian

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

8-11-86

9. AGE (In years last birthday)

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

11. BIRTHPL. ACE (County & State, or foreign country)

74 yrs.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

USA

Morris SUITE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT
(Yes, no, or unknown) (If yes give rank or grade of service)

No

Rosie WILLIAMS

Address

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)171X
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause first.
} DUE TO
(b).
DUE TO
(c)

None Mrs. Evelyn Black (D), same as #2 above

INTERVAL BETWEEN
ONSET AND DEATHPenal shutdown with terminal
Carcinoma of the cervix

2 yrs.

MEDICAL CERTIFICATION

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED?

YES NO 20e. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that X (this hospital) attended the deceased from May 9, 1961 to June 22, 1961, that X (we) last saw the deceased alive on June 22, 1961, and that death occurred at 6:35 AM from the causes and on the date stated above.

22. SIGNATURE
ARTHUR O. ANCTIL, JR., LT, MC, USN
NAME (Type)M.D. ATTENDING PHYS.
MED. DIRECTOR STAFF PHYS. 22b. DATE SIGNED
6-22-61

Arthur O. ANCTIL, JR., LT, MC, USN U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial June 24, 1961

23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS

23d. LOCATION (City, town or county) (State)

Asbury Cemetery

Barstow

Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

Harkness Funeral Home, Mutual, Md.

25e. REC'D BY REGISTRAR DATE JUN 27 '61 25b. REGISTRAR'S SIGNATURE

Arthur S. Krause



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4 must be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 2 Form G200

1. PLACE OF DEATH B. COUNTY	Montgomery		MARYLAND		1 month		1 wk		06903	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	Bethesda		c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. CITY OR TOWN (if outside corporate limits, write RT and give nearest town)		f. IS RESIDENCE ON A FARM?	
Suburban Hospital		1 month		Gaithersburg Delta		Rt. #3 Asbury Methodist Home		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
Robert	H.	Craig	June	10	19	61				
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.		
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	3/13/72	89 yrs.	Months	Days	Hours	Min.		
10a. JSLAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
Farm Owner		Agri.		Delta, Penna.		USA				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		
Henry Craig		Elizabeth Myers		No		---		Mrs. Edith Morris, Delta, Penna.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)		DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause (c)		INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 20.)		19. WAS AUTOPSY PERFORMED?				
		OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<input type="checkbox"/> YES <input type="checkbox"/> NO				
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)				
Hour a.m. p.m.	19	White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>								
21. I certify that (I) (this hospital) attended the deceased from		6/11/61		to		6/11/61		that (I) (we) last saw the deceased alive on		
22a. SIGNATURE		Arthur F. Woodward		M.D.		ATTENDING PHYS.	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		Arthur F. Woodward		22d. ADDRESS		Rockville - MD.			June 10, 1961	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county)		(State)		
BURIAL		June 13, 1961		STATE RIDGE		DELTA PA.				
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25e. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
John H. Harless, DELTA, PA.				DATE JUN 13 '61		Charles S. Kraus				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6917

CERTIFICATE OF DEATH

Reg. Dist. No. 06004

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Brooksville		a. STATE	Maryland
c. LENGTH OF STAY IN 1b		75 yrs.		b. COUNTY	Montgomery
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
				d. STREET ADDRESS	
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First Ober	Middle William	Last DAILEY	4. DATE OF DEATH	Month June	Day 13	Year 1961
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5. SEX Male	6. COLOR OR RACE Wh.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 10, 1886	9. AGE (In years last birthday) 75 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Painter	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY U.S.
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13. FATHER'S NAME Andrew J. Dailey	14. MOTHER'S MAIDEN NAME Savilla Nicholson
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 220-34-8041	17. INFORMANT Mrs. Nellie Howes - daughter - Brookville, Md.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		5-6 hrs.
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		years.
DUE TO (c) Chronic Pulmonary Fibrosis & Emphysema		years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Aortic Aneurysm.		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ AM, from the causes and on the date stated above.	
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ACTUAL SIGNATURE <i>Richard A. Yates, M.D.</i>	ADDRESS (Street, city or town, state) OLNEY Md.	DATE SIGNED 6-13-61
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PHYSICIAN'S NAME (Type) Richard A. YATES

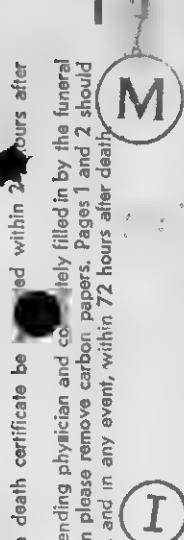
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-15-61	22c. NAME OF CEMETERY OR CREMATORIUM Brooksville	22d. LOCATION (City, town, or county) (State) Brooksville, Mont. Md.
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Francis H. Barber</i>	ADDRESS Laytonsville, Md.	24a. REC'D BY REGISTRAR DATE JUN 19 '61	24b. REGISTRAR'S SIGNATURE <i>Orlina S. Thrall</i>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for us as the mail-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1. PLACE OF DEATH
a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN lb

MARYLAND

1 day

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington Sanitarium & Hosp.

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

Archie R. Daniels

5. SEX

Male

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

April 23 - 1901

9. AGE (in years
last birthday)

60 yrs

IF UNDER 1 YEAR
Months Dey

IF UNDER 24 HRS.
Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Painter

10b. KIND OF BUSINESS OR INDUSTRY

Construction

11. PLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Horace Daniels

14. MOTHER'S M AIDEN NAME

Mary MacNamey

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and date of serv.)

None

16. SOCIAL SECURITY NO.

17. INFORMANT

Patient

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

19-22 DUE TO

Conditions, if any, which
give rise to immediate cause
(e), stating the underlying
cause last.

(b)

DUE TO

(c)

Congestive failure
Arteriosclerotic heart disease, myocardial infarction
Tuberculosis

INTERVAL BETWEEN
ONSET AND DEATH
Two days
Two days
?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While at work Not While at work
p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)
(County)
(State)

21. I certify that (I) (this hospital) attended the deceased from 6/19/1961 to 6/19/1961, that (I) (we) last saw the deceased alive on 6/19/1961, and that death occurred at 12: M^on^on from the causes and on the date stated above.

22a. SIGNATURE

Chas H. Wolton

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

Chas H. Wolton

M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

22d. ADDRESS

7600 Carroll Ave Takoma Park, Md.

23a. BURIAL, CREMATION, DATE THEREOF

REMOVAL (Specify) Burial June 23, 1961

23c. NAME OF CEMETERY OR CREMATORIUM

St John's Cemetery

23d. LOCATION (City, town or county) (State)

Beltsville, Md.

24. FUNERAL DIRECTOR'S SIGNATURE

F. Glaser Son 4739 Bldg. Ave Hyattsville, Md.

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DATE JUN 23 '61 C. L. Thomas



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6919

CERTIFICATE OF DEATH

06906

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN lb 2 years	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8714 CAMERON STREET., APT. #208		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
3. NAME OF DECEASED (Type or print) CLIFFORD		First Norton	Middle DAVIS
4. SEX MALE		5. COLOR OR RACE WHITE	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
7. MARITAL STATUS RETIRED - RAILROAD ENGINEER		8. DATE OF BIRTH NOV. 23, 1893	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY MAIN	
11. BIRTHPLACE (County & State, or foreign country) Maine		12. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min. 67 yrs.	
13. FATHER'S NAME Horace Davis		14. MOTHER'S Maiden Name Maude Norton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service) Yes		16. SOCIAL SECURITY NO. 17. INFORMANT Kathryn Noonan Davis, 8714 Cameron St., SS., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH 4 HRS.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b.) } DUE TO } (c.)		SEVERAL YEARS.	
CORONARY OCCLUSION			
CORONARY ATHEROSCLEROSIS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) PEPTIC ULCER	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JUN. 27, 1961 to JUNE 17, 1961 , that (I) (we) last saw the deceased alive on JUNE 17, 1961 , and that death occurred at 10:30P.M. from the causes and on the date stated above.		22b. DATE SIGNED JUNE 17, 1961	
22a. SIGNATURE James A. Roberts		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS	
22c. PHYSICIAN'S NAME (Type) JAMES A. ROBERTS M.D.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF June 20, 1961		23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cemetery	
23d. LOCATION (City, town or county) Montgomery County, Maryland		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Wayne E. Pulpfrey, Inc.		25a. REC'D BY REGISTRAR DATE JUN 22 '61	
ADDRESS Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL **ATTENDING PHYSICIAN:** The law requires that the death certificate be signed by a retained by the physician or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 4 may be retained by the physician or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6920

06907

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Kensington

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Kensington Gardens Sanitarium

3. NAME OF
DECESSED
(Type or print)

PAUL

A.

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Chevy Chase

d. STREET ADDRESS

5600 Western Avenue

Lest

Month

June 2,

19 61

4. DATE
OF
DEATH

DAVIS

B. DATE OF BIRTH

June 2, 1888

9. AGE (In years
last birthday)

IF UNDER 1 YEAR

Months

Days

Hours

Min.

73 yrs.

IF UNDER 24 HRS

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

President

10b. KIND OF BUSINESS OR INDUSTRY

Electrical
Fixture Firm

11. BIRTHPLACE (County & State, or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

James P. Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service)

No

16. SOCIAL SECURITY NO., 17. INFORMANT

Yes

Unknown Imogene E. Davis-Wife-same 2d

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

150 ~ DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Circulatory Failure

Generalized arteriosclerosis

INTERVAL BETWEEN
ONSET AND DEATH

2 1/2 years

14. MOTHER'S MAIDEN NAME

Mildred Hill

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED

Who a

Not Who a

at work at work

20e. PLACE OF INJURY Home, farm,

factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 5-27, 1961, to 6-2, 1961, that (I) (we) last saw the deceased alive on 6-2, 1961, and that death occurred at 11:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE

R. Hammond Misk

M.D. ATTENDING PHYS
22d. ADDRESS

MED. DIRECTOR STAFF PHYS.

22b. DATE SIGNED
June 2/61
Washington, D. C.

22c. PHYSICIAN'S
NAME (Type)

KEMP H. MISH

23c. NAME OF CEMETERY OR CREMATORIUM

Rock Creek Cemetery

23d. LOCATION (City, town or county)

(State)

23b. DATE THEREOF

6/5/61

ADDRESS

Bethesda, Maryland

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

JUN 8 '61

Linus L. Evans

24 FUNERAL DIRECTOR'S SIGNATURE

Robert A. Pumphrey

1 hours after
death. Page 4 may be retained by the physician or attending physician.

M

1

I

o

1

VR A15 (4)
15M 9/60



1

M

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

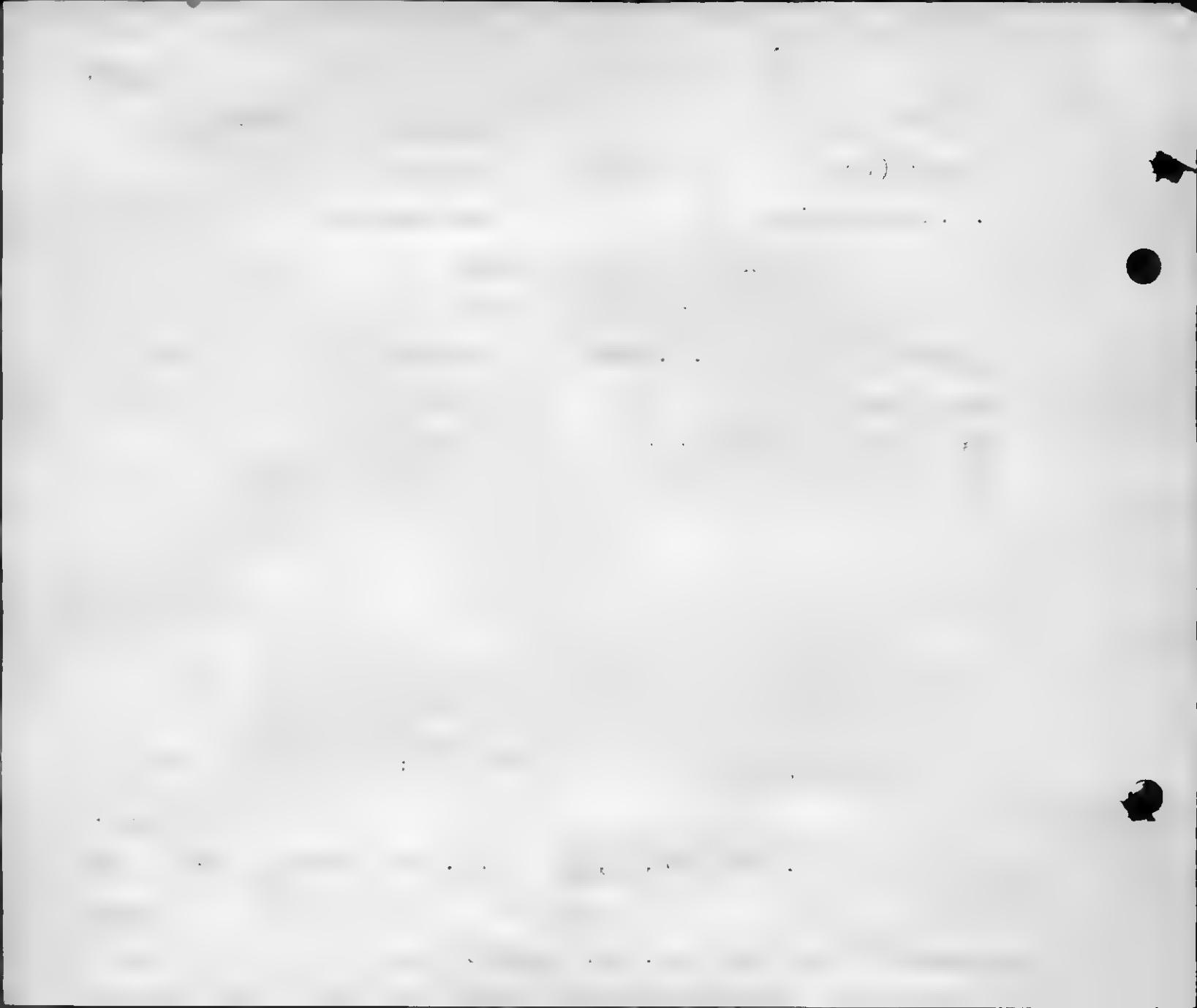
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6921

06909

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		b. COUNTY Montgomery	
c. LENGTH OF STAY IN lb 267 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS Chevy Chase Club	
3. NAME OF DECEASED (Type or print) Oliver Lee		First	Middle
4. SEX Male		5. COLOR OR RACE Caucasian	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
7. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		8. 10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
9. 10c. FATHER'S NAME Samuel DOWNES		10. 10d. BIRTHPLACE County & State, or foreign country Delaware	
11. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (Give year or dates of service) Yes 9/6/08 to 1/47		12. CITIZEN OF WHAT COUNTRY? USA	
16. SOCIAL SECURITY NO 264-54-5908		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		<i>Carcinoma of colon (cecum)</i>	
PART I. DEATH WAS CAUSED BY: AMEDIATE CAUSE (a) 1/30		INTERVAL BETWEEN ONSET AND DEATH DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	
		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that ME (this hospital) attended the deceased from Sept. 27, 1960 to June 21, 1961 , that ME (we) last saw the deceased alive on June 21, 1961 , and that death occurred at ME , from the causes and on the date stated above.		22b. DATE SIGNED 6-21-61	
22a. SIGNATURE <i>Larry J. Hines</i>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
22c. PHYSICIAN'S NAME (Type) Larry J. HINES, CDR, MC, USN		23d. LOCATION (City, town or county) (State) Arlington Virginia	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-23-61	
23c. NAME OF CEMETERY OR CREMATORIAL Arlington National		23d. LOCATION (City, town or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Jos. Gawlers & Sons</i>		25a. REC'D BY REGISTRAR DATE JUN 26 '61	
ADDRESS 1756 Penna. Ave., NW, WASHDC		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6822

CERTIFICATE OF DEATH

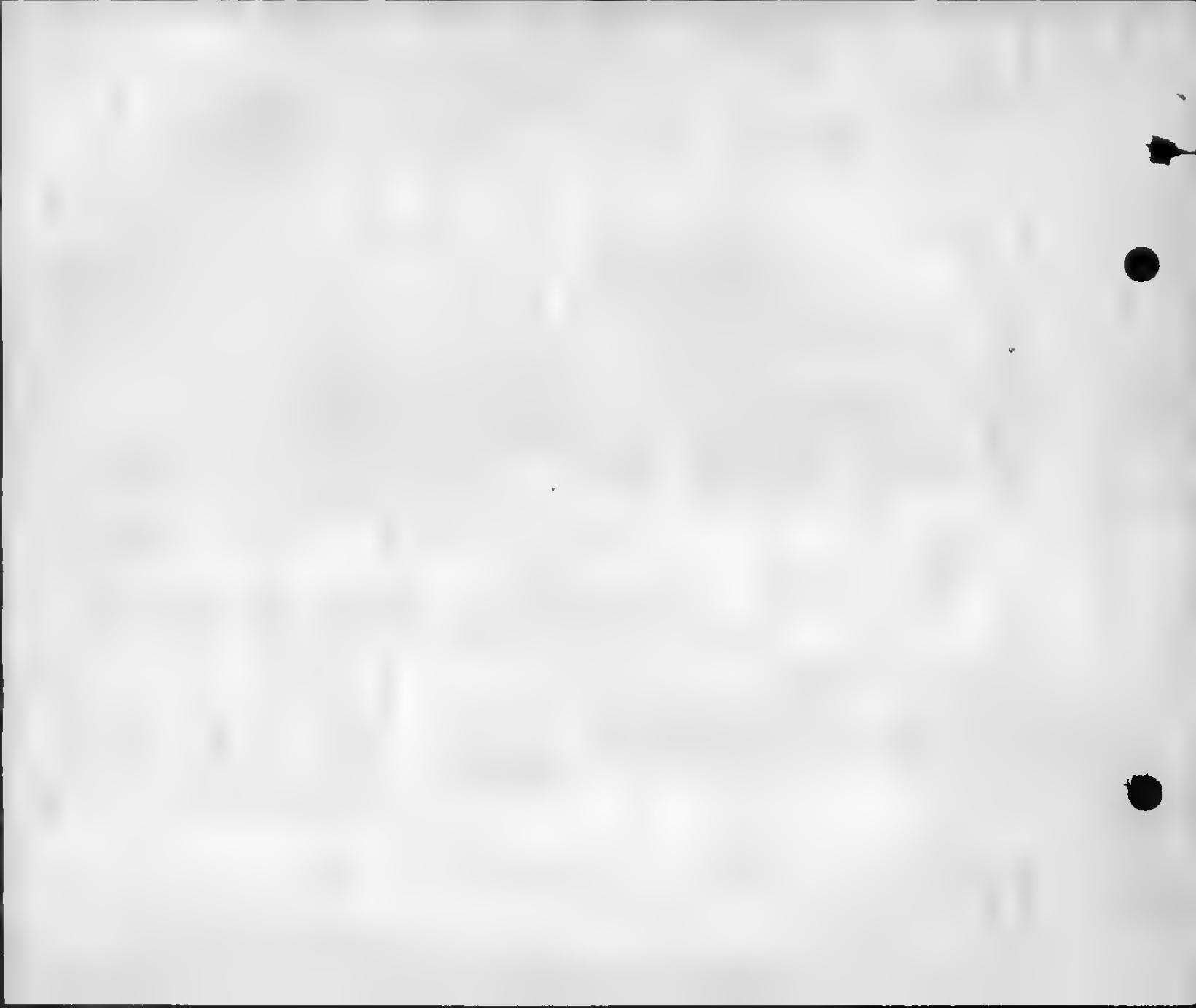
Reg. Dist. No.

CC910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		d. STREET ADDRESS 16757 Eastern Avenue		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium and Hospital		e. DATE OF DEATH June 20 1961		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Carrie	First Carrie	Middle Lucille	Last Drummond	Month June	Day 20	Year 1961		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 13, 1886	9. AGE (In years last birthday) 74 yrs.	10. IF UNDER 1 YEAR Months 0		11. IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME John Gilbert		14. MOTHER'S MAIDEN NAME Louisa Grossman						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Washington Sanitarium and Hospital Records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute coronary occlusion								
4/20/1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Severe coronary insufficiency minutes								
DUE TO (c) Severe arteriosclerosis years								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) 9/18/61, to 6/20/61		20f. (City or town) Baltimore	(County) Baltimore	(State) Md.
21. I certify that I attended the deceased from 9/18/61, to 6/20/61 , that I last saw the deceased alive on 6/19/61 , and that death occurred at 4/20/61 N, from the causes and on the date stated above.								
ACTUAL TIME 12 P.M. ADDRESS (Street, city or town, state) 2030 Carroll Ave Takoma Park 12 Md.								
PHYSICIAN'S NAME (Type) H. T. Morse								
22a. BURIAL, CREMATION, REMOVAL (Specify) Fallen June 22-61		22b. DATE THEREOF June 22-61		22c. NAME OF CEMETERY OR CREMATORIUM Holyoke Park Cemetery		22d. LOCATION (City, town, or county) Baltimore - Md.		
22e. FUNERAL DIRECTOR'S SIGNATURE Arthur Watters 251 Carroll St. NW - D.C.		ADDRESS Arthur Watters 251 Carroll St. NW - D.C.		24a. REC'D BY REGISTRAR JUN 23 '61		24b. REGISTRAR'S SIGNATURE Charles E. Morse		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6923

06911

1. PLACE OF DEATH
a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2023 Lanier Drive

3. NAME OF
DECEASED
(Type or print)

Cora

First

MARYLAND

c. LENGTH OF STAY IN 1b

31 years

2. USUAL RESIDENCE (Where deceased lived, If institution, Res before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

d. STREET ADDRESS

id 8

b. IS RESIDENCE
ON A FARM?
YES NO

5. SEX

6. COLOR OR RACE

Female

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED DIVORCED 9. AGE (In years
last birthday)

61

yrs.

10. IF UNDER 1 YEAR

Months

Days

11. IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPL. ACE, County & State, or foreign country)

Practical Nurse

Baltimore, Maryland

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Israel Deacon Yocom

Abbie G. Huffman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown) (If yes give war and date of service)

No

57R-42-1746

Mrs. Arthur L. Hanson 2023 Lanier Drive

Address
Silver Spring, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

15-2-7

DUE TO

Conditions, if any which
gave rise to immediate cause
(b), stating the underlying
cause last.

(b)

DUE TO

(c)

Carcinoma of intestine
(small) tract.INTERVAL BETWEEN
ONSET AND DEATH2½ to 3
years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.20d. INJURY OCCURRED
While Not While
at work at work

20e. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 7/5/1960 to 6/21/1961, that (I) (we) last
saw the deceased alive on June 21, 1961, and that death occurred at 3 A.M. from the causes and on the date stated above.

22a. SIGNATURE

O. B. Little

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED
June 21, 196122c. PHYSICIAN'S
NAME (Type)

A. B. Little MD 6911 Fifth Street, N.W. Washington D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county)

(State)

Burial

6/23/61

Forest Oak Cemetery

Gaithersburg, Montgomery, Md.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

25a. REC'D BY REGISTRAR

Warner E. Humphrey

25b. REGISTRAR'S SIGNATURE

Raymond A. Knapp

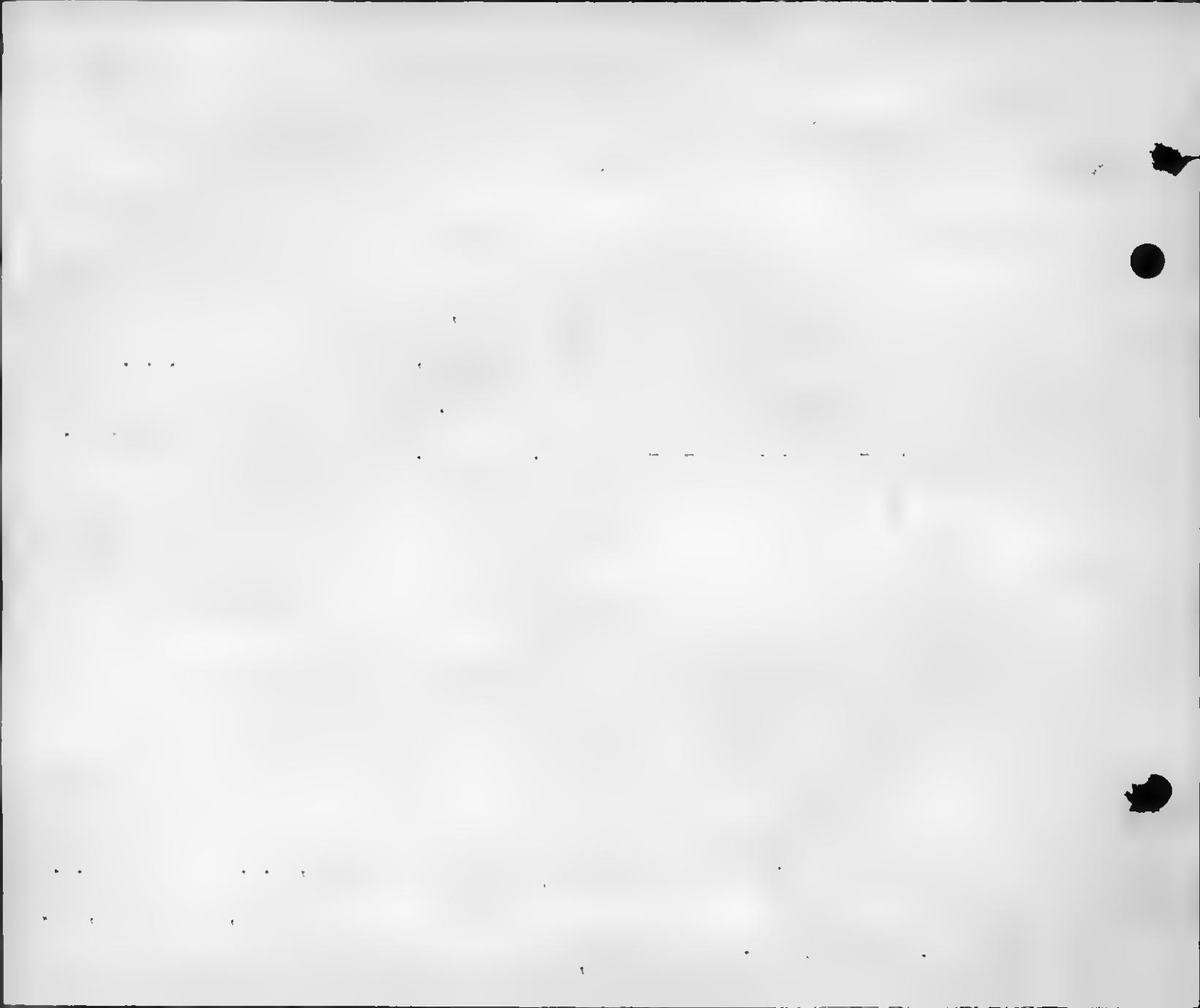
ADDRESS
Inc. 8434 Georgia Avenue

DATE JUN 27 '61

Silver Spring, Maryland

Luther S. Krause

(Signature)



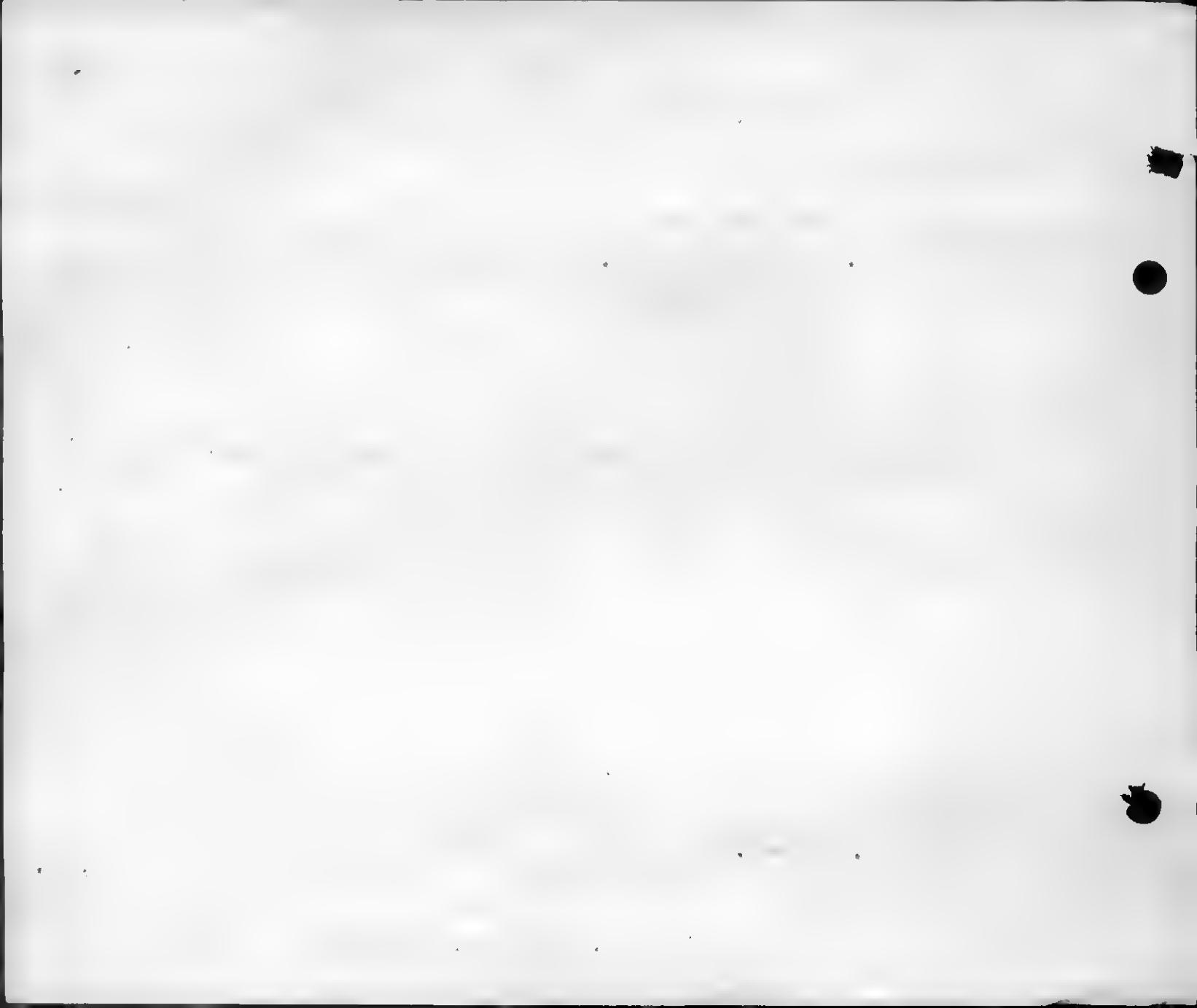
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6924

08158

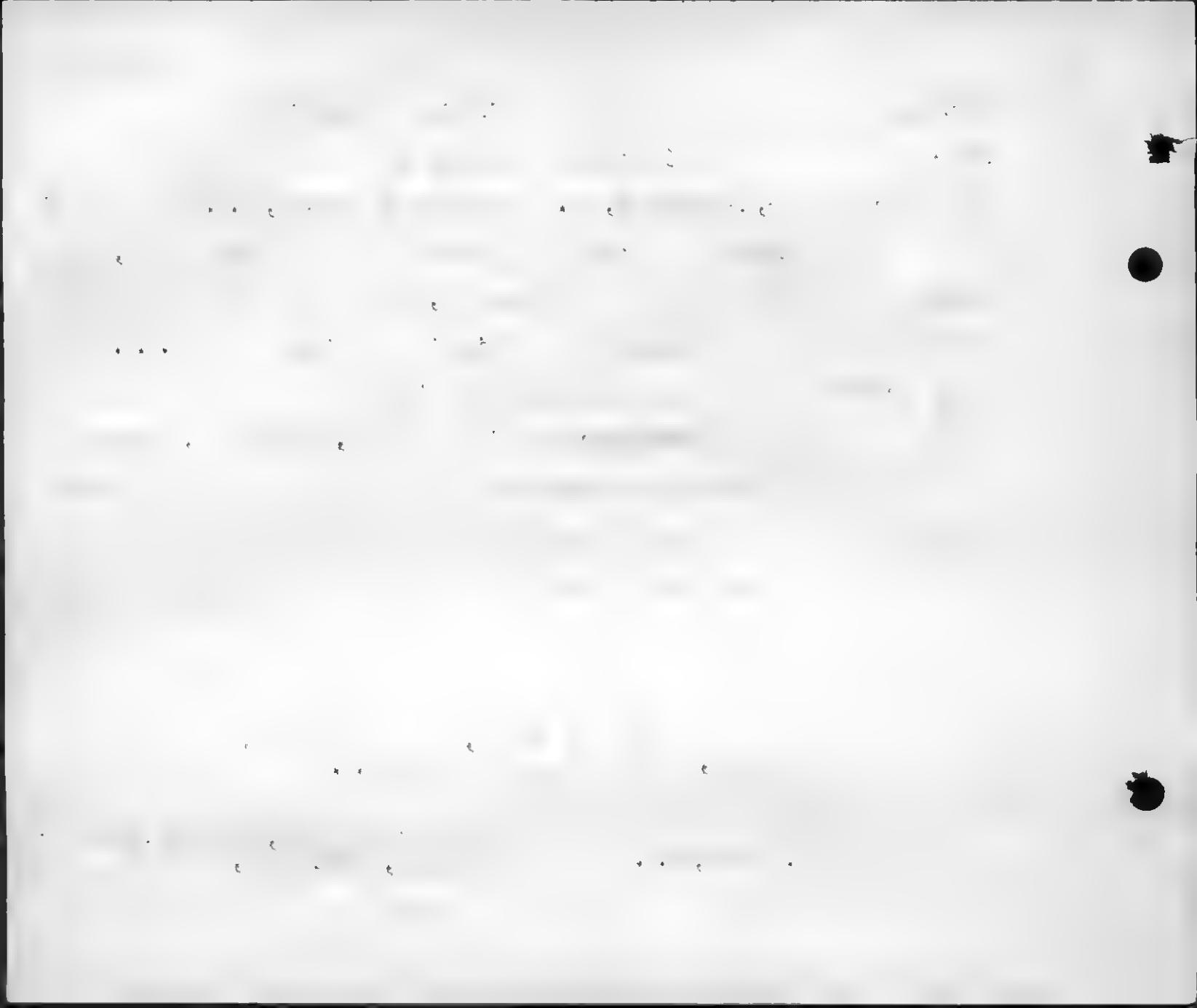
1. PLACE OF DEATH a. COUNTY Montgomery		Item 9 File G292 8/15/61		2 ^a USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3404 W. Coquelin Ter. Ch. Ch. Md.		c. LENGTH OF STAY IN lb		d. STREET ADDRESS <i>21</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cherry Chase Md.												
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CH. CH. MD.												
3. NAME OF DECEASED (Type or print) Mrs. Mary H. Durbin		First	Middle	Last	4. DATE OF DEATH Month June	Month 28	Day	Year 1961				
S SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Feb. 15 1883	9 AGE (in years last birthday) 78 10 yrs.		10 IF UNDER 1 YEAR Months 78 10 yrs.		11. IF UNDER 24 HRS. Hours 1					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife,		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Bolling Green, Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME Patrick Fleming,		14. MOTHER'S MAIDEN NAME Margaret Howard										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO.		17. INFORMANT Margaret P. Durbin-		Address 3404-W. Coquelin Ter. Ch. Ch. Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO <i>Congestive heart failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>420.1</i>		(b)	DUE TO <i>Coronary artery disease</i>	10 years								
DUE TO <i>Cerebral vascular disease, Diabetes Mellitus, Pulmonary embolism</i>		(c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Car accident from home, Diabetes Mellitus, Pulmonary embolism</i>										
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 1130 M.		(County)		(State)		
19												
21. I certify that (I) (this hospital) attended the deceased from Jan 29 , 1964, to Dec 28 , 1961, that (I) (we) last saw the deceased alive on Dec 26 , 1961, and that death occurred at 1130 M. from the causes and on the date stated above.												
22a. SIGNATURE <i>Blaine H. Egig</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> 22b. DATE SIGNED <i>1961</i>										
22c. PHYSICIAN'S NAME (Type) Dr. Blaine H. Egig		22d. ADDRESS 8641 Colesville Road,										
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 7-3-61		23c. NAME OF CEMETERY OR CREMATORIAL Bowling Green		23d. LOCATION (City, town, or county) Kentucky						
24. FUNERAL DIRECTOR'S SIGNATURE <i>Thomas B. Houston</i>		ADDRESS 3831 Ga. Ave. N.W.		25a. REC'D BY REGISTRAR JUL 18 '61		25b. REGISTRAR'S SIGNATURE <i>Ernest L. Thomas</i>						



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o STATE District of Columbia		COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 30 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 210 Cromwell Terrace, N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Agnes	Middle Mary	Last Dyson	4. DATE OF DEATH April 15, 1968	Month June	Day 22	Year 1961		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1908		9. AGE (In years last birthday) 53	IF UNDER 1 YEAR Months 5		IF UNDER 24 HRS Hours 3	
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress		10b. KIND OF BUSINESS OR INDUSTRY Laundry		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Henry Duckett		14. MOTHER'S MAIDEN NAME Janie Williams							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Unavailable		The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Metastases from							1 month		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last X							1 year		
(b) DUE TO Carcinoma of Cervix with							3 month		
(c) DUE TO Metastases to lung									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) May 23, 1961		(County) June 22, 1961	(State) MD
21. I certify that (I) (this hospital) attended the deceased fram saw the deceased alive an June 22, 1961		19		to 6:00 a.m.		, 1961, that (I) (we) last from the causes and on the date stated above			
22a. SIGNATURE Donald L. Morton, M.D.		ATTENDING PHYS <input type="checkbox"/>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE 6/22/61	
22c. PHYSICIAN'S NAME (Type) DONALD L. MORTON, M.D.		22d. ADDRESS LINCOLN MEM. CEMETERY SUITLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/30/1961		23c. NAME OF CEMETERY OR CREMATORIAL LINCOLN MEM. CEMETERY SUITLAND, MD.		23d. LOCATION (City, town, or county) SUITLAND, MD.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Alex. L. Morton		ADDRESS 414-15 1/2 ST SE		25a. REC'D BY REGISTRAR JUN 23 1961		25b. REGISTRAR'S SIGNATURE Carling S. Thomas			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-travel permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 6289 6/26/61 ink

6926

CERTIFICATE OF DEATH

Reg. Dist. No.

06913

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD		b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING Hyattsville		d. STREET ADDRESS FAIRFIELD NURSING HOME			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAIRFIELD NURSING HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First ALICE	Middle E. EBERHART	Lost	4. DATE OF DEATH 6 - 18 - 1961	Month	Day	Year	
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-28-66	9. AGE (In years last birthday) 95 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE MD		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME JACOB PARKER				14. MOTHER'S MAIDEN NAME UNKNOWN					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO NONE		17. INFORMANT WILLIAM F. EBERHART		Address 5504 43RD PLACE HYATTSVILLE MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0		DUE TO Benefit		INTERVAL BETWEEN ONSET AND DEATH about 4 years					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO Generalized arteriosclerosis		unable to state					
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 8237 Georgia Ave Silver Spring MD		20f. (City or town) 8237 Georgia Ave Silver Spring MD		(County) 6/19/61	
21. I certify that I attended the deceased from Sept 4, 1957 , to June 18, 1961 , that I last saw the deceased alive on June 11, 1961 , and that death occurred at 8237 Georgia Ave Silver Spring MD . M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 8237 Georgia Ave Silver Spring MD		DATE SIGNED 6/19/61			
ACTUAL SIGNATURE Aaron H. Traum		M.D.							
PHYSICIAN'S NAME (Type) PARRON H. TRAUM									
22a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-21-1961		22c. NAME OF CEMETERY OR CREMATORY BALTIMORE CITY CEM		22d. LOCATION (City, town, or county) BALTIMORE MD		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. Riverdale Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 21 '61		24b. REGISTRAR'S SIGNATURE John S. Traum			



HOSPITAL OR HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death by a physician or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06914

6927		M		I				
1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE [Where deceased lived, If institution: Residence before admission] a. STATE Maryland		b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b # 1 Year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 105 James St.		d. STREET ADDRESS 105 James St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) AGNES		First	Middle	Last	4. DATE OF DEATH Month June Day 19 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13 1890		9. AGE (In years less birthday) yrs 71	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min 0	
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pract. Nurse		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph Harrison			14. MOTHER'S MAIDEN NAME Cornelia Warthen			Address Same As 2		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No						16. SOCIAL SECURITY NO. 578 36 8319		
17. INFORMANT Leslie E. Mullineaux						18. INTERVAL BETWEEN ONSET AND DEATH		
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 170X (b) Inoperable Cancer of breasts (c) Possible generalized metastasis						20. DUE TO		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from April 1961 to April 1961 , that (I) (we) last saw the deceased alive on April 1961 , and that death occurred at Maryland , from the causes and on the date stated above.						22. SIGNATURE Lucinda L. Leal		
22a. SIGNATURE L. L. Leal						M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED April 1961	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Gaithersburg, Md.						
23a. BURIAL CREMATION, REMOVED (Specify) Burial		23b. DATE THEREOF June 22 1961		23c. NAME OF CEMETERY OR CREMATORY Hyattstown		23d. LOCATION (City, town, or county) Hyattstown (State) Md.		
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber						ADDRESS Laytonsville, MD.	25a. REC'D BY REGISTRAR DATE JUN 26 '61	
25b. REGISTRAR'S SIGNATURE Cynthia S. Evans								

970 ft track

1000 ft - 1000 ft 9.0 m apart

start position 310-8 10.22-9

1000 ft
2000 ft

1000 ft
1000 ft

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6928

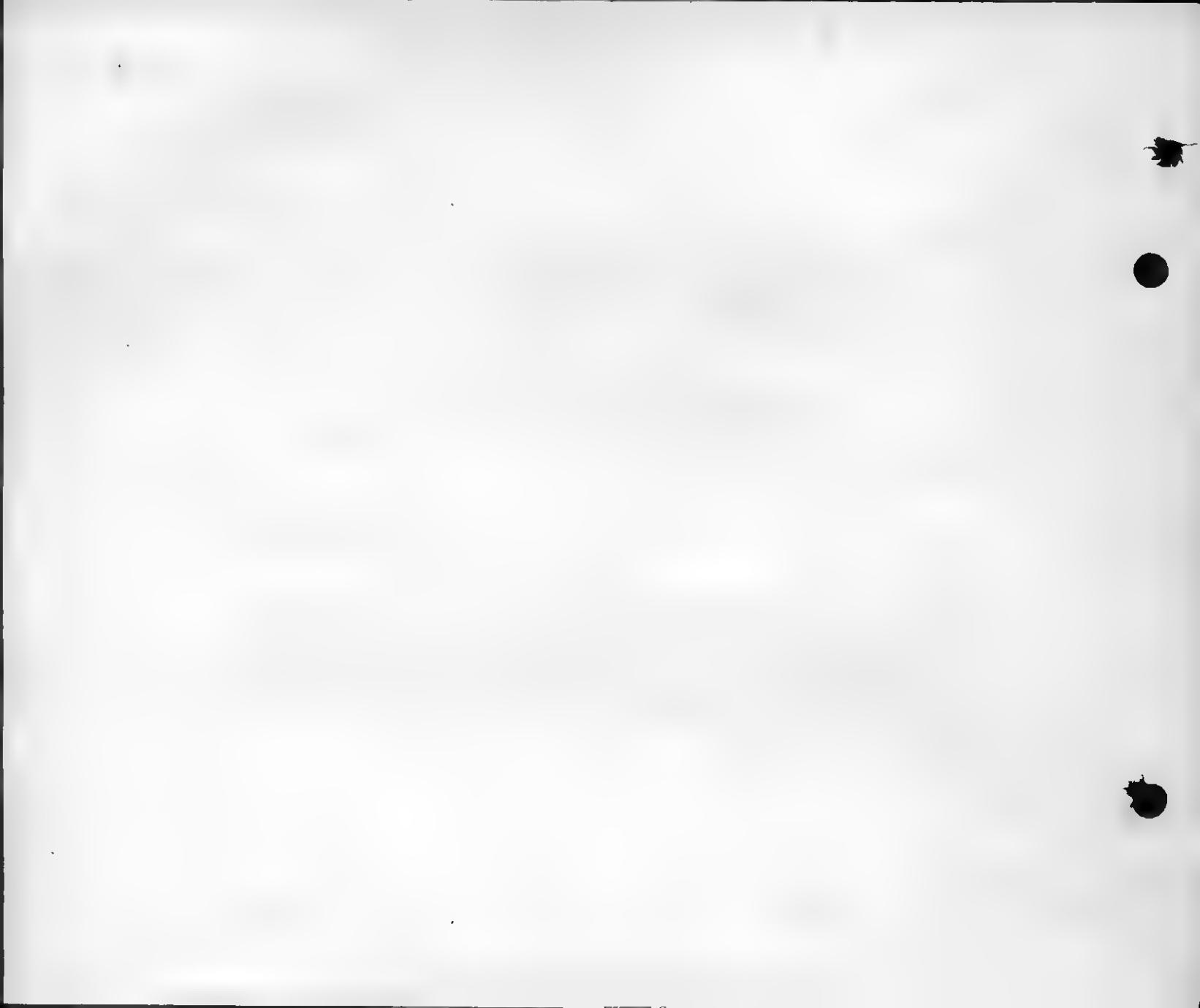
06915

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN TB 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Xolney		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF (Type or print)		First Samuel	Middle Josiah	Last Finneyfrock	4. DATE OF DEATH	Month 6	Day 11	Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/28/1885	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith		10b. KIND OF BUSINESS OR INDUSTRY Blacksmith		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Samuel Finneyfrock				14. MOTHER'S MAIDEN NAME Anna Schutly					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown. (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-34-1061		17. INFORMANT Hospital Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331X Conditions if any, which gave rise to immediate cause (a), stating the under- lying cause last } (b) Cerebral Arterio Sclerosis DUE TO (c) years									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Olney		(County) Md.	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from 6/11/1961 to 6/11/1961 , that (I) (we) last saw the deceased alive on 6/11/1961 , and that death occurred at Olney, Md. from the causes and on the date stated above									
22a. SIGNATURE Richard Dr. Yates, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/11/1961			
22c. PHYSICIAN'S NAME (Type) Dr. Yates				22d. ADDRESS Olney, Md.					
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-14-61		23c. NAME OF CEMETERY OR CREMATORIAL St. John's Cemetery		23d. LOCATION (City, town, or county) Olney, Md.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Franicia K. Barber		ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR JUN 19 '61		25b. REGISTRAR'S SIGNATURE Linnet S. Krause			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY MONTGOMERY						2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRLAND						c. LENGTH OF STAY IN lb 4/9/61 - 6/8/61					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAIRLAND NURSING Home						e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Holmes Chapel					
3. NAME OF DECEASED (Type or print) Jessie MARIE Fitzwater						d. STREET ADDRESS 2526 Buck Lodge Rd.					
3. SEX Female		4. COLOR OR RACE White		5. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		6. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		7. DATE OF DEATH June 3 - 1896		8. AGE (in years last birthday) 65 yrs	
9. IF UNDER 1 YEAR Months 0		10. IF UNDER 24 HRS. Days 0		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Joseph Manuel						14. MOTHER'S M AIDEN NAME Eva Meeks					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. 3					
17. INFORMANT Hospital Records											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 250X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)											
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cute Cardiac Failure											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) While at work		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 419 (County) 18 (State) MD	
21. I certify that (I) (this hospital) attended the deceased from 4/9/61 to 6/8/61 , that (I) (we) last saw the deceased alive on 6/8/61 , and that death occurred at 18 M, from the causes and on the date stated above.											
22a. SIGNATURE J.E. VIRNSTEIN						22b. DATE SIGNED 6/8/61					
22c. PHYSICIAN'S NAME (Type) J.E. VIRNSTEIN		22d. ADDRESS 3311-16-772 Nash St. N.W. Washington, D.C.									
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 6/10/61		23c. NAME OF CEMETERY OR CREMATORIAL Valley View Cemetery		23d. LOCATION (City, town, or county) (State) Nokesville, Va.					
24. FUNERAL DIRECTOR'S SIGNATURE St. Hines Co 2901 145th NW						25a. ADDRESS ADDRESS		25b. REC'D BY REGISTRAR DATE JUN 9 '61		25c. REGISTRAR'S SIGNATURE Walter S. Thomas	



TO HOSPITAL OR HOSPITAL DIRECTOR: This law requires that the death certificate be executed within 4 hours after the deceased has been signed by the attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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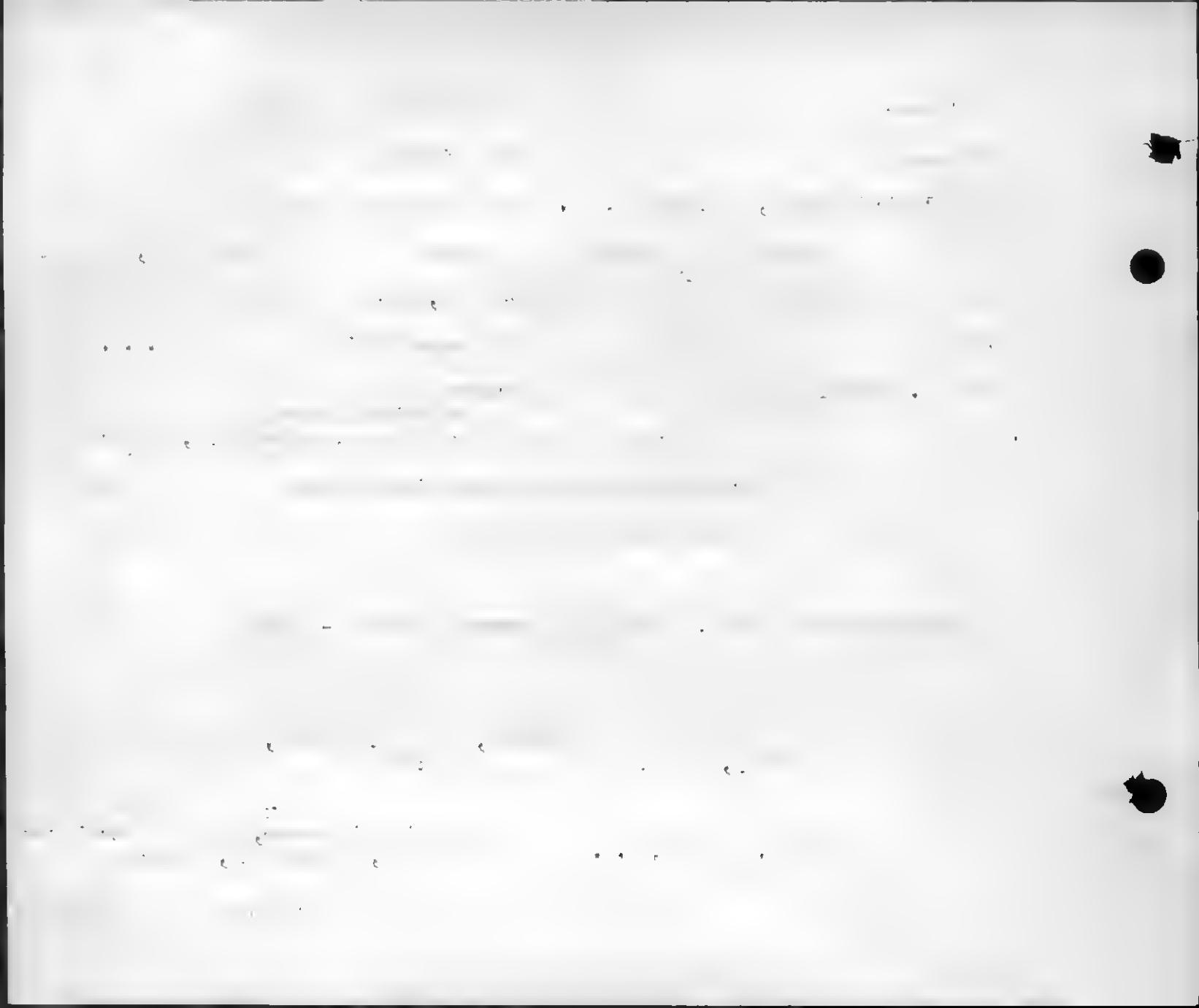
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06917

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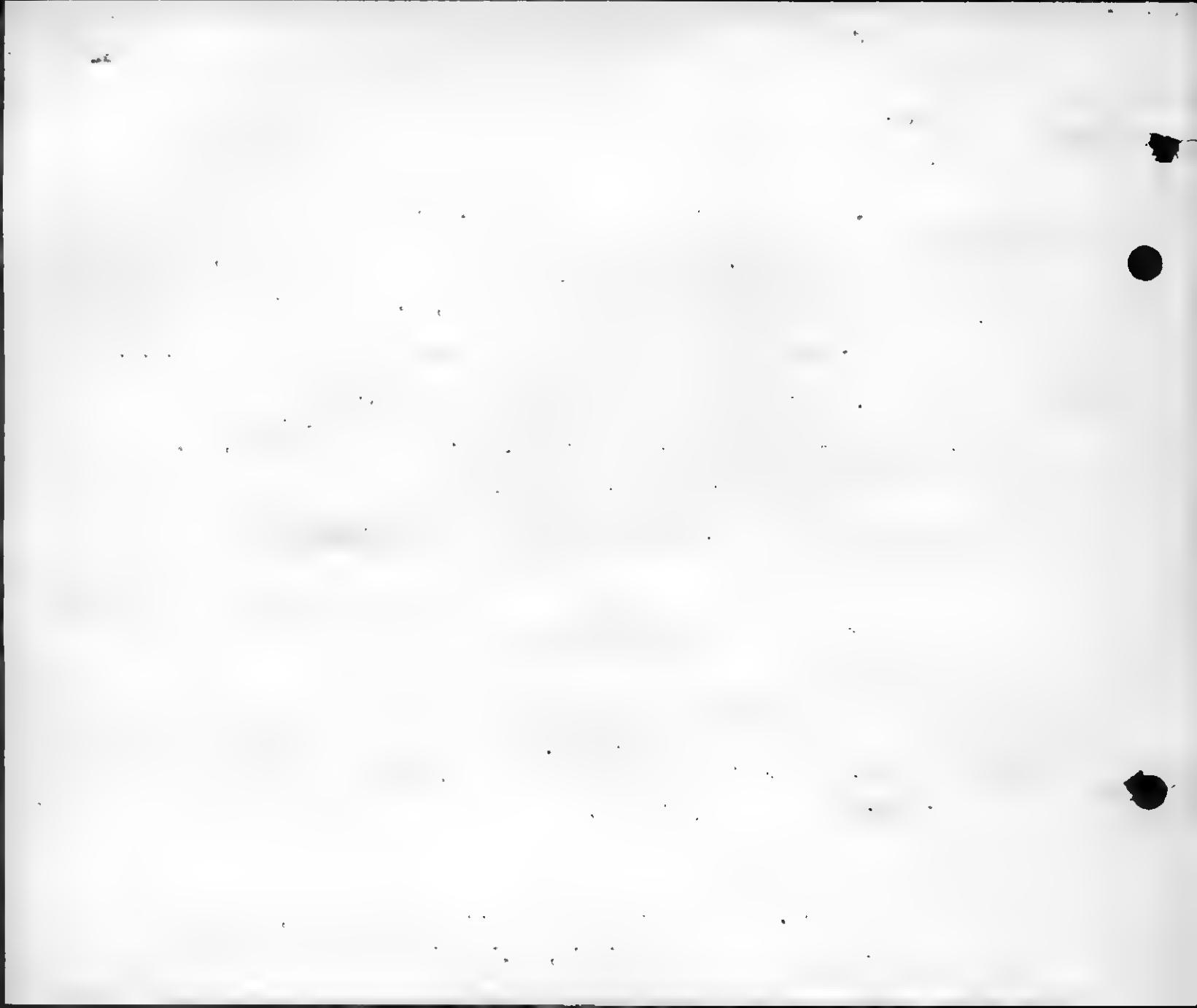
1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Pennsylvania		b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Pittston		d. STREET ADDRESS 906 Susquehanna Avenue				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First John	Middle Harold	Last Flannery	4. DATE OF DEATH April 19, 1898	Month June	Day 3,	Year 19 61		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19, 1898	9. AGE (In years from birthday) 63	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min 0	
10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) Judge			10b. KIND OF BUSINESS OR INDUSTRY Law			11. BIRTHPLACE (State or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John T. Flannery				14. MOTHER'S MAIDEN NAME Brigid Tighe						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO Unknown		17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute & chronic respiratory insufficiency										INTERVAL BETWEEN ONSET AND DEATH years
526X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		DUE TO (b) Bronchiectasis & emphysema								years
		DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Atherosclerosis of aorta, coronaries & cerebral vessels - severe										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)
19						June 2, 1961		June 3, 1961		
21. I certify that (I) (this hospital) attended the deceased from June 3, 1961 , and that death occurred at 6:30PM on June 3, 1961 , that (I) (we) last saw the deceased alive on June 3, 1961 , and that death occurred at M. from the causes and on the date stated above										22b. DATE SIGNED 6/4/61
22a. SIGNATURE <i>C.W.McBride</i>		M.D.		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland			
22c. PHYSICIAN'S NAME (Type) Orlando W. McBride, M.D.										
23a. BURIAL, CREMATION, REMOVAL* (Specify) BURIAL		23b. DATE THEREOF 6/6/61		23c. NAME OF CEMETERY OR CREMATORIAL St. John's		23d. LOCATION (City, town, or county) Pittston, Pennsylvania		(State)		
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert C. Heneghan</i>		ADDRESS <i>Bethesda, Md.</i>		25a. REC'D. BY REGISTRAR DATE JUN 8 '61		25b. REGISTRAR'S SIGNATURE <i>Cecilia S. Times</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

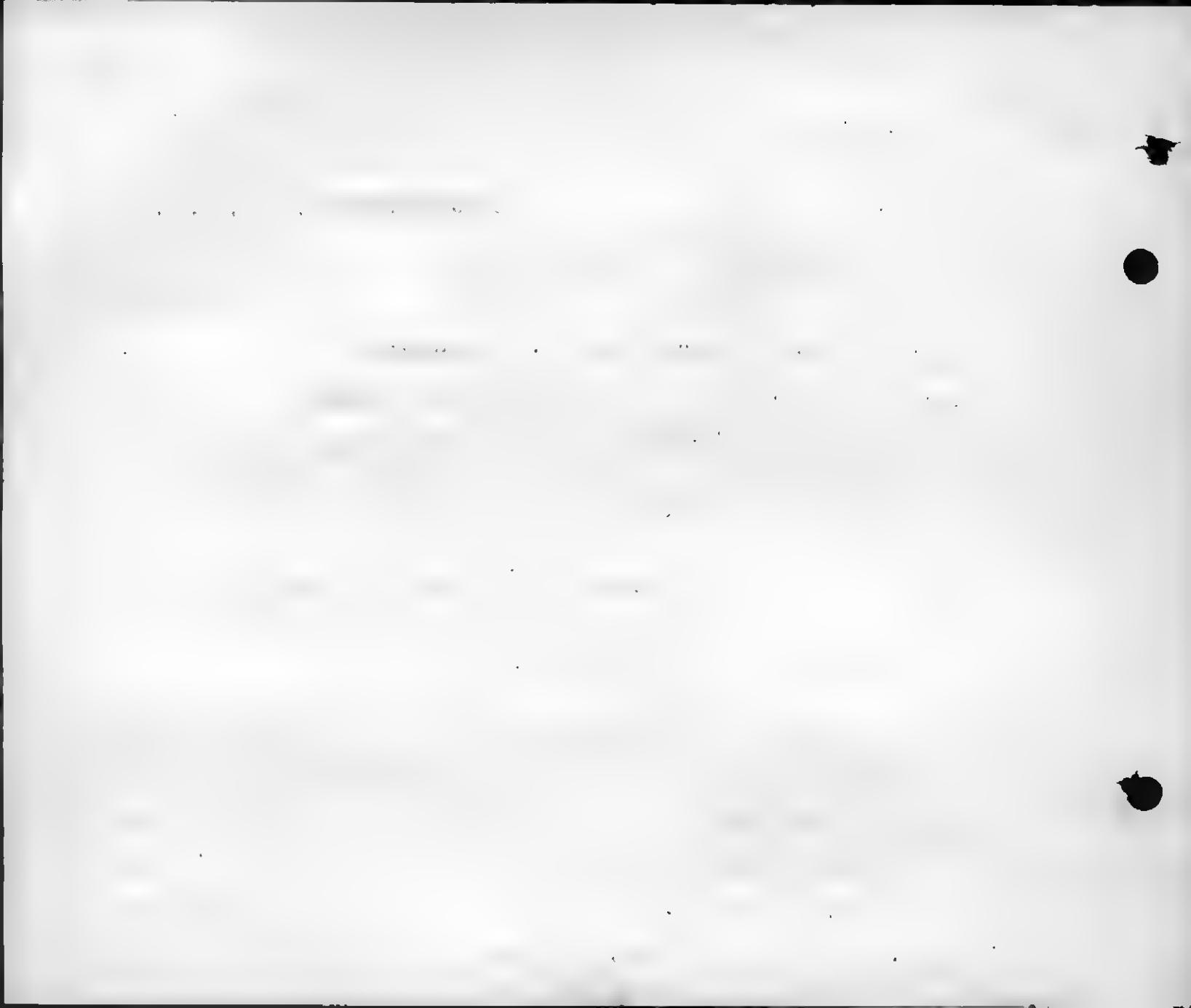
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18														
6931		Item 9 Film G-69 01-06-61		i.w.k.		Reg. Dist. No.		06918						
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY Montgomery			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland			b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rockville			d. STREET ADDRESS 5 E. Argyle Street					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5 E. Argyle Street									e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Julia	Middle M.	Last Foley		4. DATE OF DEATH Month June 21,		Year 19 61						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 3, 1887		9. AGE (In years last birthday) 74 1/2 yrs.		10. IF UNDER 1 YEAR Months 74		11. IF UNDER 24 HRS. Days 112		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse (retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Robert J. Foley			14. MOTHER'S MAIDEN NAME Julia Meagher											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. World War I		17. INFORMANT --		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2865 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Myocardial failure few days (c) DUE TO Malnutrition, mental depression 1 year.		19. INTERVAL BETWEEN ONSET AND DEATH 1 year.						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Radiotherapy for carcinoma of breast 1949.			20c. TIME OF INJURY Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from June 15 1961 , to June 21, 1961 , that I last saw the deceased alive on June 15 1961 , and that death occurred at 7:00 AM , from the causes and on the date stated above.									22. ADDRESS (Street, city or town-state) 110 S. Washington St. Rockville, Md.			DATE SIGNED 6/23/61		
ACTUAL SIGNATURE W. J. Linticum		PHYSICIAN'S NAME (Type) WILLIAM A. LINTHICUM, M.D. 110 South Washington St.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22c. NAME OF CEMETERY OR CREMATORIUM Mount Maria Cemetery			22d. LOCATION (City, town, or county) Towson			(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home			ADDRESS 133½ E. Montg. Ave. Rockville, Md.			24a. REC'D BY REGISTRAR DAJUN 23 '61			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					



TO HOSPITAL OR HOSPITAL DIRECTORY: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND												06919							
CERTIFICATE OF DEATH																			
PLACE OF DEATH a. COUNTY Montgomery				MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a STATE Maryland				b. COUNTY D C							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 4½ days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				d. STREET ADDRESS 4200 Cathedral Avenue, N.W.							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban												e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print)		First Franklin		Middle (nmi)		Last FORD		4 DATE OF DEATH June 5		Month 161		Day	Year						
5. SEX Male		6 COLOR OR RACE White		7 MARRIED WIDOWED		NEVER MARRIED DIVORCED		8. DATE OF BIRTH 2/2/90		9. AGE (In years last birthday) 71 yrs		IF UNDER 1 YEAR 4 Months	IF UNDER 24 HRS 3 Days						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Advertising Manager				10b. KIND OF BUSINESS OR INDUSTRY Bogley Reas Est.				11. BIRTHPLACE (State or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME Henry Jones Ford				14. MOTHER'S MAIDEN NAME Bertha Batory								Address							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Unknown		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 416X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Myocardial Infarction, massive Coronary insufficiency Old inactive Rheumatic heart disease		19. INTERVAL BETWEEN ONSET AND DEATH 5 days				20. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) No accident				20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) May 12, 1961, to June 5, 1961		(County) Prince Georges County		(State) MD	
21. I certify that (I) (his/hospital) attended the deceased from June 5, 1961 and that death occurred at 11:59 PM , from the causes and on the date stated above.								22. SIGNATURE George Buchanan				M.D. <input type="checkbox"/> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22b. DATE SIGNED June 5, 61					
22c. PHYSICIAN'S NAME (Type) George Buchanan				22d. ADDRESS 1834 Eye St. N.W. Wash. D.C.				23d. LOCATION (City, town, or county) Prince Georges Maryland				(State)							
23a. BURIAL, CREMATION OR REMOVAL (Specify) Cremation		23b. DATE THEREOF 6/6/1961		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory				23d. LOCATION (City, town, or county) Prince Georges Maryland				(State)							
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland				25a. REC'D BY REGISTRAR DATE JUN 8 1961				25b. REGISTRAR'S SIGNATURE Robert A. Pumphrey							
VR A15 (4) 1SM 9/59																			



HOSPITAL OR HOSPITAL OR
ING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after the deceased has been signed by the attending physician and completely filled in by the funeral director.

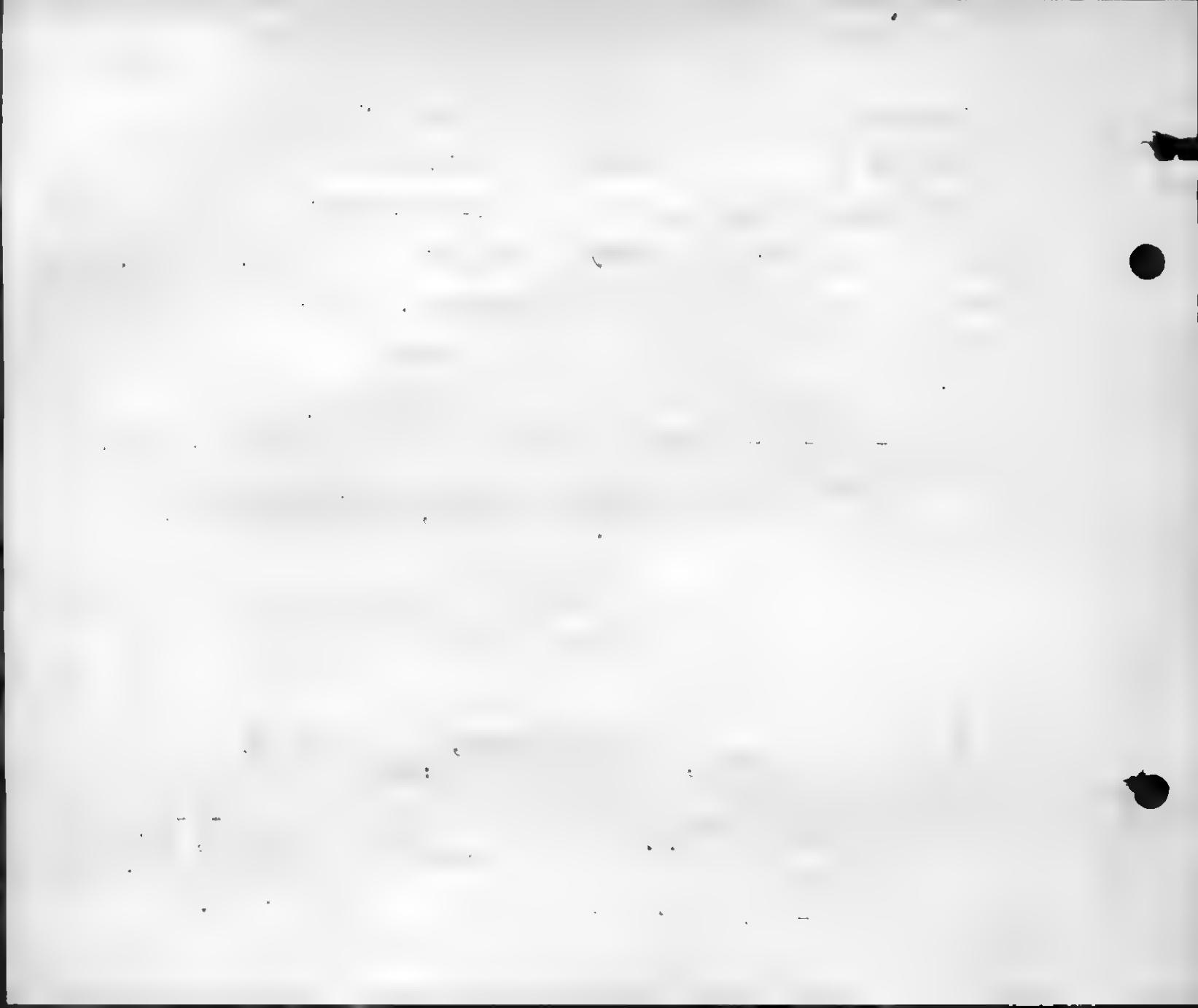
FUNERAL DIRECTIONS: Her this certificate has been signed by the attending physician and completely filled in by the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Pennsylvania		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 29 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Uniontown		d. STREET ADDRESS 31 Evans Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center						<input checked="" type="checkbox"/> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Helen		First	Middle	Last	4. DATE OF DEATH Calderisi	Month June	Day 12	Year 19 61
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 15, 1905		9. AGE (in years last birthday) 55 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George Koballa			14. MOTHER'S MAIDEN NAME Mary Hardy					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchiogenic Carcinoma of Right main Bronchus DUE TO with metastasis to Adrenals, lymph Nodes, Thyroid, and pancreas. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 162 (c)								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) DUE TO								
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from May 14, 19 61 to June 12, 19 61 , that (I) (we) last saw the deceased alive on June 12, 19 61 , and that death occurred 2:15 PM from the causes and on the date stated above								
22a. SIGNATURE Leo Stolbach		M.D.		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 6-12-61	
22c. PHYSICIAN'S NAME (Type) Leo Stolbach		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland						
23a. BURIAL, CREMATION OR REMOVAL (Specify) Removal		23b. DATE THEREOF 6-13-1961		23c. NAME OF CEMETERY OR CREMATORIAL St. John's Cemetery		23d. LOCATION (City, town, or county) Hopwood, Pa. (State)		
24. FUNERAL DIRECTOR'S SIGNATURE Joseph J. Givens, Inc.		ADDRESS 1756 E. 2nd Ave., J. J. G.		25a. REC'D BY REGISTRAR DATE JUN 14 '61		25b. REGISTRAR'S SIGNATURE Charles S. Meiss		



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH o COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Res since before admission) o. STATE Maryland	
6. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c LENGTH OF STAY IN 1b 41 days	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) /6 Rockville	
3. NAME OF DECEASED (Type or print) RUTH		4. DATE OF DEATH Last Month Day Year GENIES June 13, 1961	
First Middle		5. SEX Female	
6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH September 14, 1914		9. AGE (In years last birthday) 46 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
10c. BIRTHPLACE (State or foreign country) Maryland		11. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Reuben Dove		14. MOTHER'S MAIDEN NAME Flora Hogan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Not available	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 17+X		INTERVAL BETWEEN ONSET AND DEATH 3 wks	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO Pseudomonas Septicemia	
{ DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 wks several months	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 3, 1961 to June 13, 1961, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 13, 1961, and that death occurred at 11:25 AM from the causes and on the date stated above		22b. DATE SIGNED 6/13/61	
22a. SIGNATURE David J. Crawford M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) David T. Crawford, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL/CREMATION Burial (specify)		23b. DATE THEREOF 6/17/61	
23c. NAME OF CEMETERY OR CREMATORIAL Lincoln Park,		23d. LOCATION (City, town, or county) Rockville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Sonder		25a. REC'D BY REGISTRAR DATE JUN 20 '61	
ADDRESS Rockville, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06922

6935

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE		Maryland b. COUNTY		Montgomery							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 903 Malcolm Drive				903 Malcolm Drive											
3. NAME OF DECEASED (Type or print)		<i>Geoghegan, Earl</i>		4. DATE OF DEATH		Month	Day	Year							
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) 81 yrs		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours	13. Min		
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2-19-1880									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S.N. Air Stat		11. BIRTHPLACE (State or foreign country) Shelby County, Ky		12. CITIZEN OF WHAT COUNTRY? U. S. A.									
13. FATHER'S name John Geoghegan				14. MOTHER'S MAIDEN NAME Elizabeth Caplinger											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 400 28 2119		17. INFORMANT Claude Geoghegan		Address Same as # 2									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]															
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)															
450.0 <i>Senility</i>															
Conditions if any, wh ch gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized arteriosclerosis</i>															
DUE TO (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
<i>Arterosclerotic Heart Disease</i>															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>															
MEDICAL CERTIFICATION															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i>None</i>		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) <i>None</i>		20f. (City or town) <i>None</i>		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.															
22a. SIGNATURE <i>Bernard A. Fitzgerald</i>				M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>6-17-61</i>							
22c. PHYSICIAN'S NAME (Type) Bernard A. Fitzgerald				22d. ADDRESS <i>217 UNIVERSITY BLVD E S.E. Md.</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-20-1961		23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven		23d. LOCATION (City, town, or county) Silver Spring, Md		23e. (State)							
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Mattingly</i>		ADDRESS <i>131-11 1/2 S Washington</i>		25a. REC'D BY REGISTRAR DATE JUN 21 '61		25b. REGISTRAR'S SIGNATURE <i>Charles S. Kline</i>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										06923		
CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland					b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney			c LENGTH OF STAY IN TB 57½ hours		e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg					d. STREET ADDRESS Box 3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hospital										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First ERNEST	Middle DIONISUS	Last GLOYD	4. DATE OF DEATH 6 1 1961		Month	Day	Year			
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/12/88			9. AGE (In years last birthday) 72 yrs	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS Hours 0 Min 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) insurance agent			10b. KIND OF BUSINESS OR INDUSTRY insurance			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jacob A. Gloyd					14. MOTHER'S MAIDEN NAME Elizabeth Clents							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>			16. SOCIAL SECURITY NO. (If yes, no, or unknown) <input type="checkbox"/>		17. INFORMANT hospital records		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BILATERAL BRONCHOPNEUMONIA 3 days (c) MYOCARDIAL INFARCTION (OLD)										INTERVAL BETWEEN ONSET AND DEATH ? ?		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. AC. THAT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I cert (I) (this hospital) attended the deceased from 6/11/61 to 6/11/61 , that (I) (we) last saw the deceased alive on 6/11/61 and that death occurred at 7:20M , from the causes and on the date stated above.												
22a. SIGNATURE A. D. Bonifant, M.D.					M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b. DATE SIGNED SANDY SPRING, MARYLAND							
22c. PHYSICIAN'S NAME (Type) A. D. Bonifant, M.D.												
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-5-61		23c. NAME OF CEMETERY OR CREMATORIAL H Rose			23d. LOCATION (City, town, or County) Gaithersburg, Md		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE John Farmer					ADDRESS Gaithersburg, Md		25a. REC'D BY REGISTRAR Date 5 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thorne			
VR A15 (4) 15M 9/59												



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6937

06924

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rockville Park

MARYLAND

c. LENGTH OF STAY IN 1b

11 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Hash San & Hospt

3. NAME OF
DECEASED
(Type or print)

First

Middle

Joseph (MM) Gottlieb

4. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED 8. DATE
OF
BIRTH

3-7-76

Last

Month

Day

Year

4

5

1961

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired School teacher none

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

13. FATHER'S NAME

Abraham Gottlieb

14. MOTHER'S MAIDEN NAME

Judith Washevsky

12. CITIZEN OF WHAT COUNTRY

AMERICA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.

(Yes, no, or unknown) (If yes give war or dates of service)

none

17. INFORMANT

p't Hosp. record

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

572.1

DUE TO

Conditions, if any, which
gave rise to immediate cause } (b)
(a), stating the underlying }
cause last. }
(c)

Ruptured colon diverticulum

INTERVAL BETWEEN
ONSET AND DEATH

Today

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year

Hour

a.m.

p.m.

19

20d. INJURY OCCURRED
While at work Not While at work

2de. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2df. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

Oct 1957 to June 5, 1961, that (I) (we) last

saw the deceased alive on June 5, 1961, and that death occurred at 6:50 PM, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORI

23d. LOCATION (City, town or county)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

DATE JUN 7 '61

25b. REGISTRAR'S SIGNATURE

Address S. Name

ATTENDING
PHYS.

22d. ADDRESS

MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED

6/5/61



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

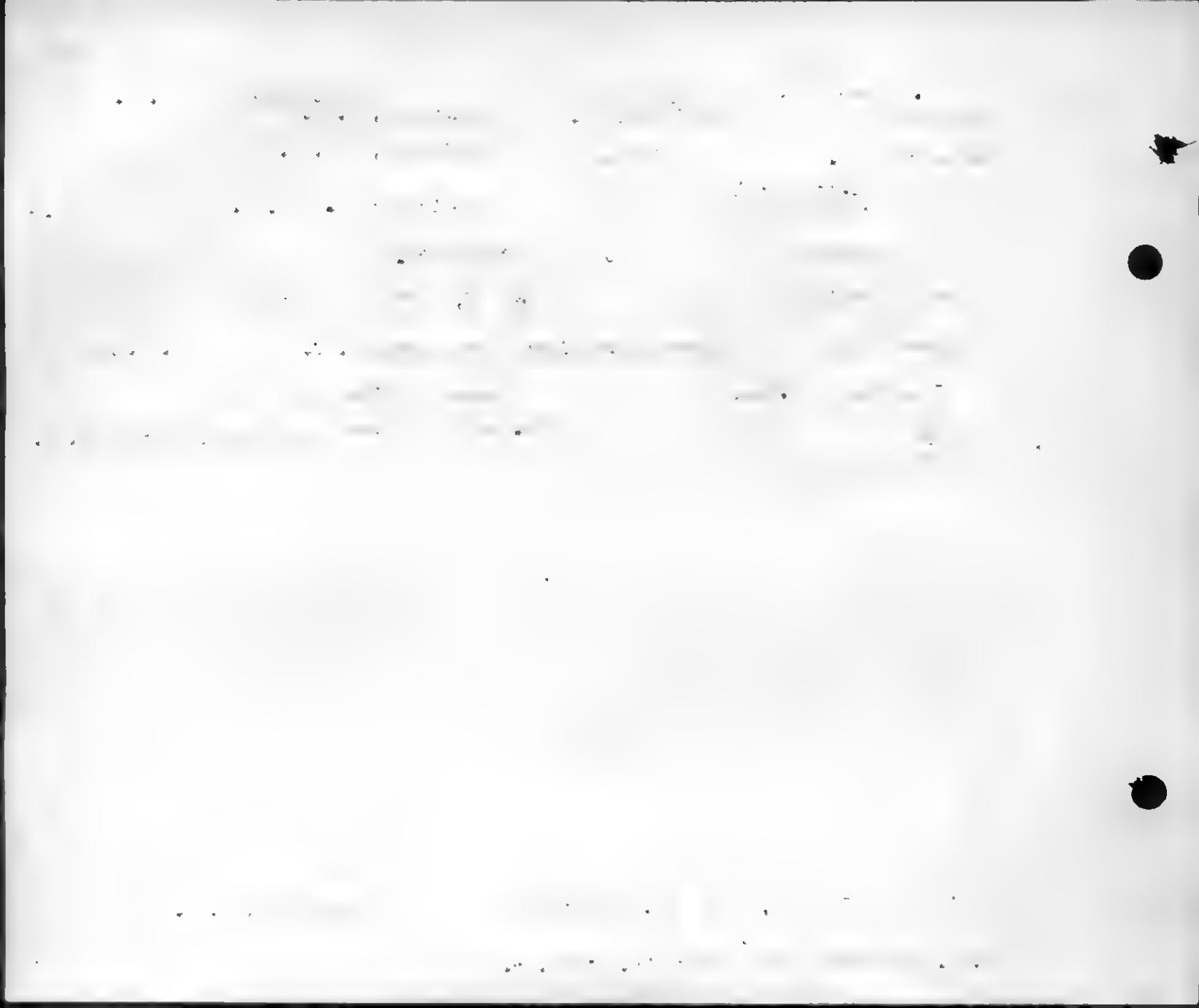
Item 9 Film 3298 6/16/61 mh

CERTIFICATE OF DEATH

Reg. Dist. No. 06925

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll Hall Rest Home Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington, D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington Md.		c. LENGTH OF STAY IN 1b Six Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Rest Home 10231 Carroll Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward		First O	Middle Graham
4. DATE OF DEATH JUNE 10 1961		Last Sr.	Month JUNE
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 8, 1876
9. AGE (In years lost birthday) 84 105 yrs		F. UNDER 1 YEAR IF UNDER 24 HRS Months 84	Days 105
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Electric Business Washington D. C.	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jonathan		14. MOTHER'S MAIDEN NAME Agnes Wise	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO INFORMANT Mrs. Marie M Milans	
		Address 816 Randolph Street N. W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY THROMBOSIS + 2001 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO ESSENTIAL HYPERTENSION GENERALIZED ARTERIOSCLEROSIS			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) SENILE IX			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MARCH 13, 1956 , to JUNE 10, 1961 , that I last saw the deceased alive on JUNE 10, 1961 , and that death occurred at 5:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Henry London</i>		ADDRESS (Street, city or town, state) 5206 Norway Dr. DATE SIGNED 6/10/61	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, (Specify) Burial		22b. DATE THEREOF June 13, 1961	
22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. K. Huntemann & Son</i>		ADDRESS 5732 Ge Ave N. W.	
		24a. REC'D BY REGISTRAR JUN 14 '61	
		24b. REGISTRAR'S SIGNATURE <i>Caroline P. K.</i>	



FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Please execute the certificate, writing the word "pending" in pencil in Item 18, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Item 3 should be used as a burial-transit permit. pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6939 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66926

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN TB

DOA

NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Suburban

3. NAME OF
DECEASED
(Type or print)

First

Middle

Anna E. Green

5. SEX

Female

6. COLOR OR RACE

Col

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

1-23-06

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Domestic

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

DC

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

U.S.A.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

578-44-0977

17. INFORMANT

Neige

Address

Elsie Moore #59-Hobart St. N.W.

INTERVAL BETWEEN
ONSET AND DEATH

sudden

years

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.1
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Coronary occlusion
hypertension

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

History of known heart disease

19. WAS AUTOPSY
PERFORMED?

YES NO

20e. EXTERNAL CAUSE WAS

PRIMARY or CONTRIBUTING CAUSE OF DEATH.

20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

20d. INJURY OCCURRED

While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

at work

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

ACTUAL
SIGNATURE

Frank J. Brochart

M.D. ASSISTANT MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S
NAME (Type)

Frank J. Brochart

DEPUTY MEDICAL EXAMINER

6-12-61

Address (Street, city, town, or county)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIAL

22d. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE

DATE JUN 16 '61

Arthur S. Krause



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6940

CERTIFICATE OF DEATH

Reg. Dist. No 06927

M

PLACE OF DEATH

o. COUNTY

Montgomery

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

o. STATE

Maryland

b. COUNTY

Frederick

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address)

OR INSTITUTION

1532 Red Oak Drive

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Point of Rocks

d. STREET ADDRESS

10 X - 1

e. IS RESIDENCE

ON A FARM?

YES NO 3. NAME OF
DECEASED
(Type or print)First
ALTAMiddle
LEONALast
HARNE4. DATE
OF
DEATHMonth
JuneDay
14Year
1961

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

10 March 1878

9. AGE (in years
from birthday)
yrs.

83

IF UNDER 1 YEAR IF UNDER 24 HRS

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

House-work

10b. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Joseph L. Redmond

14. MOTHER'S MAIDEN NAME

Oliva Pryor

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or date of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Mrs. Lillian C. Landis (Same as item #1)

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

154X

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

6 months

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Terminal hypertension

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m.
p. m.

19

20d. INJURY OCCURRED
While
at work Not while
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Dec. 30, 1960, to June 14, 1961, that I last saw the deceased alive on June 14, 1961, and that death occurred at 11:00 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURESydney Leventhal, M.D. 9210 Colesville Rd., June 14, 1961
Silver Spring, Md.PHYSICIAN'S
NAME (Type)22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

6-17-61

22c. NAME OF CEMETERY OR CREMATORIUM

Mt. Bethel Cemetery

22d. LOCATION (City, town, or county)

Frederick County Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

M. R. Etchison & Son, Frederick, Maryland

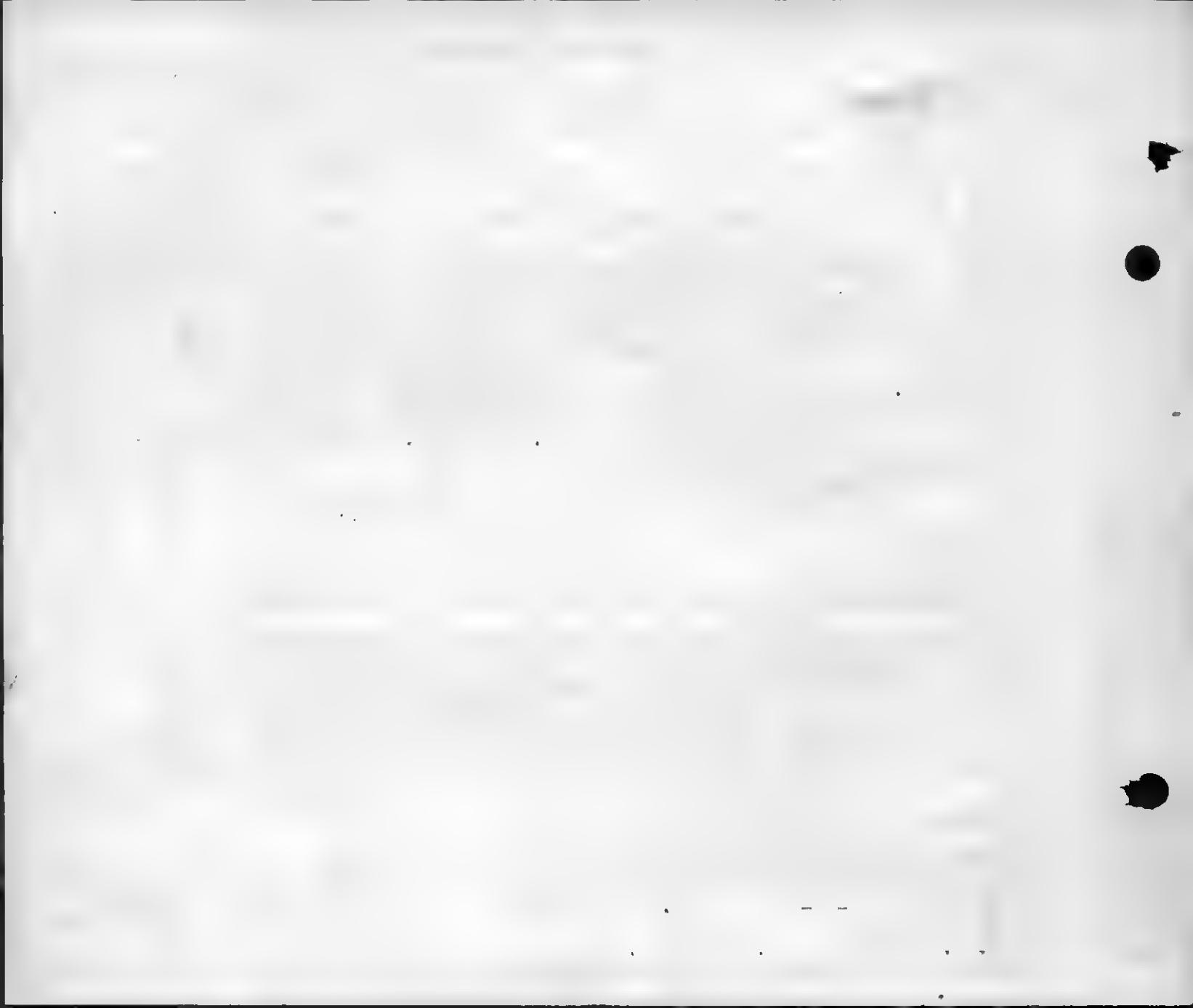
ADDRESS

24a. REC'D BY REGISTRAR

DATE JUN 16 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6941

CERTIFICATE OF DEATH

Reg. Dist. No.

C6928

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Md.		c. LENGTH OF STAY IN 1b RURAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Md.		d. STREET ADDRESS 7109 Radnor Rd.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7109 Radnor Rd.				d. STREET ADDRESS 7109 Radnor Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) HELEN		First L.	Middle HEIDER	Last Heider	4. DATE OF DEATH June 16th, 1961	Month June	Day 16	Year 1961			
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8, 1912	9. AGE (in years last birthday) 48 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. MIN. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Michael Leba		14. MOTHER'S MAIDEN NAME Anna Lechvoich									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-18-6120		17. INFORMANT Mr. William F. Heider, 7109 Radnor Rd., Bethesda, Md.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		<i>Adenocarcinoma Colon c Metastasis</i>				INTERVAL BETWEEN ONSET AND DEATH 2 years.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		<i>6 Liver, etc.</i>									
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.		20f. (City or town) 6707-16th St. N.W.		(County)		(State)	
21. I certify that I attended the deceased from July 11, 1960 , to June 16, 1961 , that I last saw the deceased alive on June 16, 1961 , and that death occurred at 10:17 A.M. from the causes and on the date stated above.											
ACTUAL SIGNATURE <i>Paul Eanet</i>											
PHYSICIAN'S NAME (Type) PAUL EANET M.D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 6/19/61		22c. NAME OF CEMETERY OR CREMATORIAL State of DeSoto Cem. Georgia Ave. SS Ma		22d. LOCATION (City, town, or county) Cherry Chase Wood Home 5193 7th and		(State) DC			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Kraus</i>		ADDRESS 5193 7th and		24a. REC'D BY REGISTRAR DATE JUN 21 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6942

CERTIFICATE OF DEATH

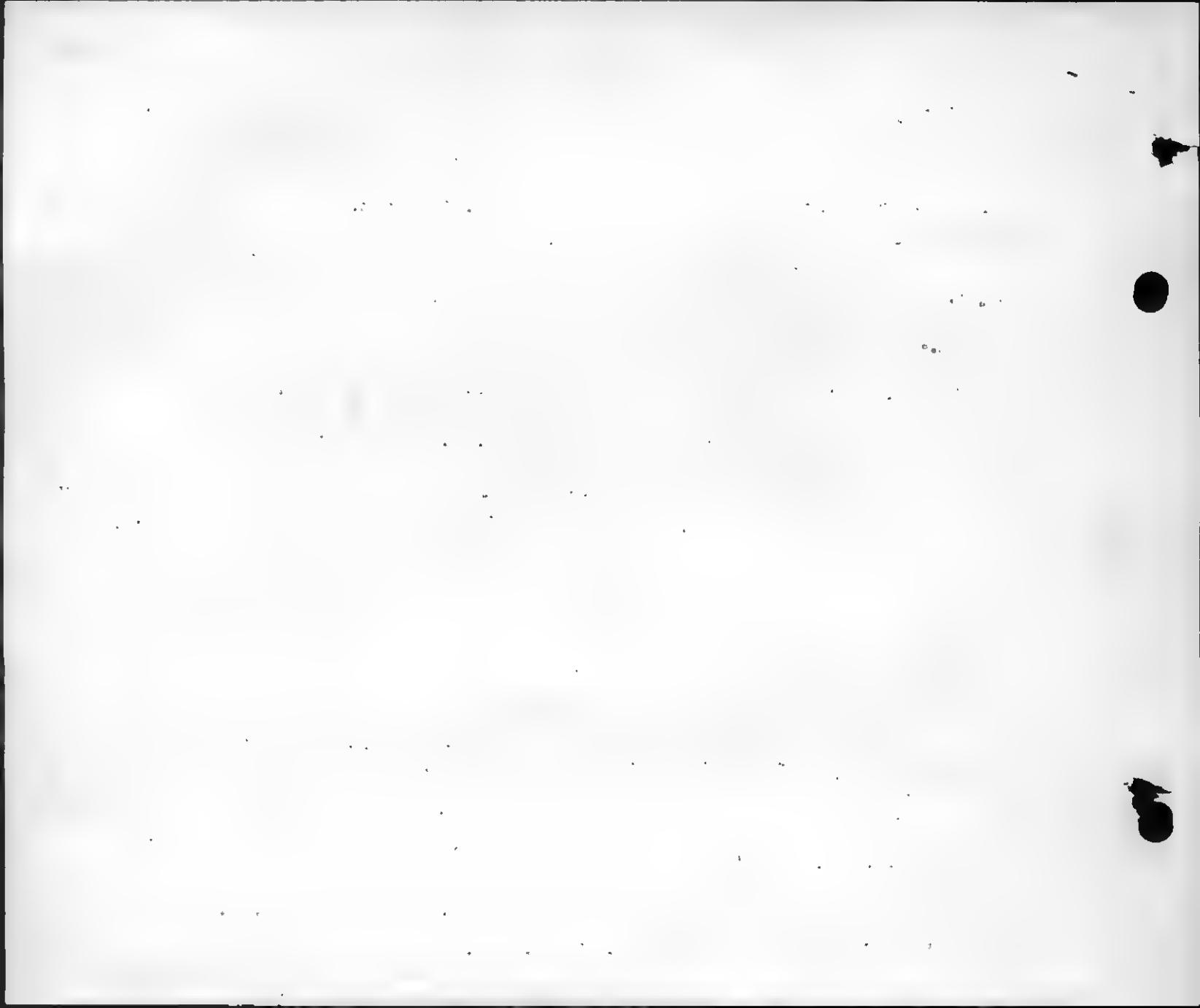
Reg. Dist. No.

06929

TO HOSPITAL may be retained
TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 1 and 2 should be filed with the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Seneca		c. LENGTH OF STAY IN 1b 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pt. # 2 Germantown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First BEDA CARLINE	Middle HELGREN	Last JANE
4. DATE OF DEATH JANE 11 1961	Month JAN	Day 11	Year 1961
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 22, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Sweeden	12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME John F. Loff		14. MOTHER'S MAIDEN NAME Wilamena Carolina	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
		INFORMANT Mrs Chas. E. Clark-Item # 2	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)			
1. MAH NUTRITION DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b)			
2. Linitus PLASTICA DUE TO 3. CARCINOMA OF STOMACH (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) DATSONVILLE (County) Md. (State) 6/11/61
21. I certify that I attended the deceased from June 1961 to 11 June 1961 , that I last saw the deceased alive on 10 June 1961 , and that death occurred at 2:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John G. Fawcett		ADDRESS (Street, city or town, state) P.O. Box 842, Md. DATE SIGNED 6/11/61	
PHYSICIAN'S NAME (Type) John G. Fawcett		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 6/13/61 22c. NAME OF CEMETERY OR CREMATORIAL Darnestown Church Cem. 22d. LOCATION (City, town or county) (State) Darnestown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland		ADDRESS Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland	24a. REC'D BY REGISTRAR JUN 13 '61 24b. REGISTRAR'S SIGNATURE John S. Kline



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6943

06950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

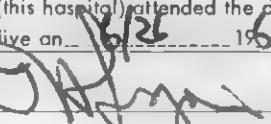
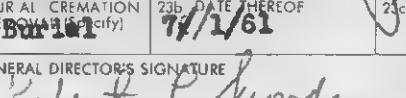
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 223 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. STREET ADDRESS P.O. Box 76	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Elaine	Middle Marie	Last Hessey
4. DATE OF DEATH	Month June	Year 1961	Day 11
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1946
9. AGE (In years at birthday) 14	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edwin Hessey		14. MOTHER'S MAIDEN NAME Gladys Biggs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown.) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACRANIAL HEMORRHAGE			
DUE TO 204			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. ACUTE MYELOGENOUS LEUKEMIA			
DUE TO 18 mos			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) October 31, 1960 to June 11, 1961 , 1:15 AM	
(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from October 31, 1960 to June 11, 1961 , that (I) (we) last saw the deceased alive on June 11, 1961 , and that death occurred at 1:15 AM from the causes and on the date stated above			
22a. SIGNATURE Emanuel S. Hellman, M.D.		22b. DATE SIGNED 6/11/61	
22c. PHYSICIAN'S NAME (Type) Emanuel S. Hellman, M.D.		22d. ADDRESS The Clinical Center National Institutes Of Health , Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 13, 1961	
23c. NAME OF CEMETERY OR CREMATORIAL Bethel Cemetery		23d. LOCATION (City, town, or county) Nr. Chesapeake City, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE ELKTON FUNERAL HOME		ADDRESS Elkton, Md.	
25a. REC'D BY REGISTRAR Donald M. Kraus		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
DATE JUN 14 '61			

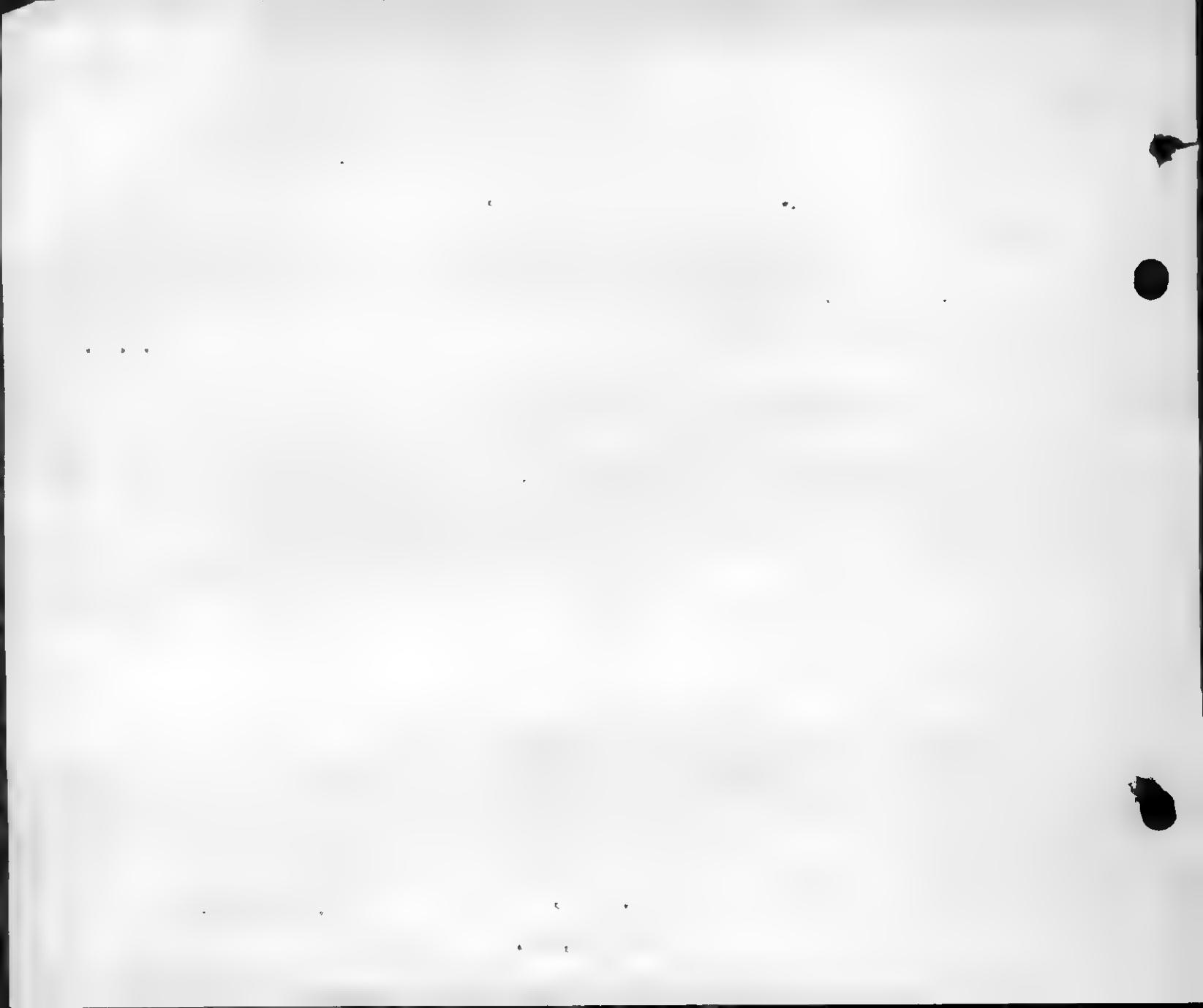


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6944

06931

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oinely		c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Box 108 Olney,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hospital				d. STREET ADDRESS Box 108			
3. NAME OF DECEASED (Type or print)		First Margaret,	Middle Elgar	Lost Hill	4. DATE OF DEATH June	Month 26	Day 1961
5. SEX Female		6 COLOR OR RACE Colored	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 5/21/1908	9. AGE (In years last birthday) 53 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Messiah Addison				14. MOTHER'S MAIDEN NAME Annie Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (if yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records Address Olney Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 191.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)				Pathological Fracture - Vertebrae. Delt Epidemoid Cervix Grade II Anterior Region Infiltration INTERVAL BETWEEN ONSET AND DEATH 1 yr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18]					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/21/61 to 6/26/61, that (I) (we) last saw the deceased alive on 6/25/61, and that death occurred at 6:30 P.M. from the causes and on the date stated above							
22a. SIGNATURE 				22b. DATE SIGNED 6/27/61			
22c. PHYSICIAN'S NAME (Type) C. H. LIGON, M. D.,				22d. ADDRESS SANDY SPRING, MARYLAND			
23a. BURIAL CREMATION RECOMMENDED (Specify) Burial		23b. DATE THEREOF 7/1/61		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion,		23d. LOCATION (City, town, or county) Mt. Zion, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE 				ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR DATE JUN 30 '61	
						25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6845

CERTIFICATE OF DEATH

Reg. Dist. No. 06932

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		d. STREET ADDRESS 9709 E. Bexhill Dr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Sanitarium				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Michael		FIRST Holland	MIDDLE 16st	4. DATE OF DEATH June 17	Month June	DAY 17	YEAR 1961
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1880	9. AGE (In years last birthday) 80	10. IF UNDER 1 YEAR Months 9	11. IF UNDER 24 HRS Days 15	12. Hours 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman - Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) London, England		12. CITIZEN OF WHAT COUNTRY? U.S.A. Naturalized.	
13. FATHER'S NAME John Holland		14. MOTHER'S MAIDEN NAME Margaret Sullivan					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No)		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Daughter Mrs. Howard H. Cork		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		DUE TO Coronary insufficiency Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral thrombosis + Anemia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour o. m. None 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/27, 1960 , to present , that I last saw the deceased alive on 6/16, 1961 , and that death occurred at 8:12 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 8805 Linn Ave		DATE SIGNED 6/17/61	
ACTUAL SIGNATURE John B Clinton		M.D.		Chang Chase 15 M.			
PHYSICIAN'S NAME (Type) JOHN B Clinton							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 6-17-61		22b. DATE THEREOF 6-17-61		22c. NAME OF CEMETERY OR CREMATORIUM Holy Cross Cemetery		22d. LOCATION (City, town, or county) Yeadon, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE JUN 21 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

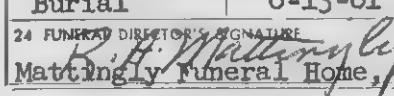


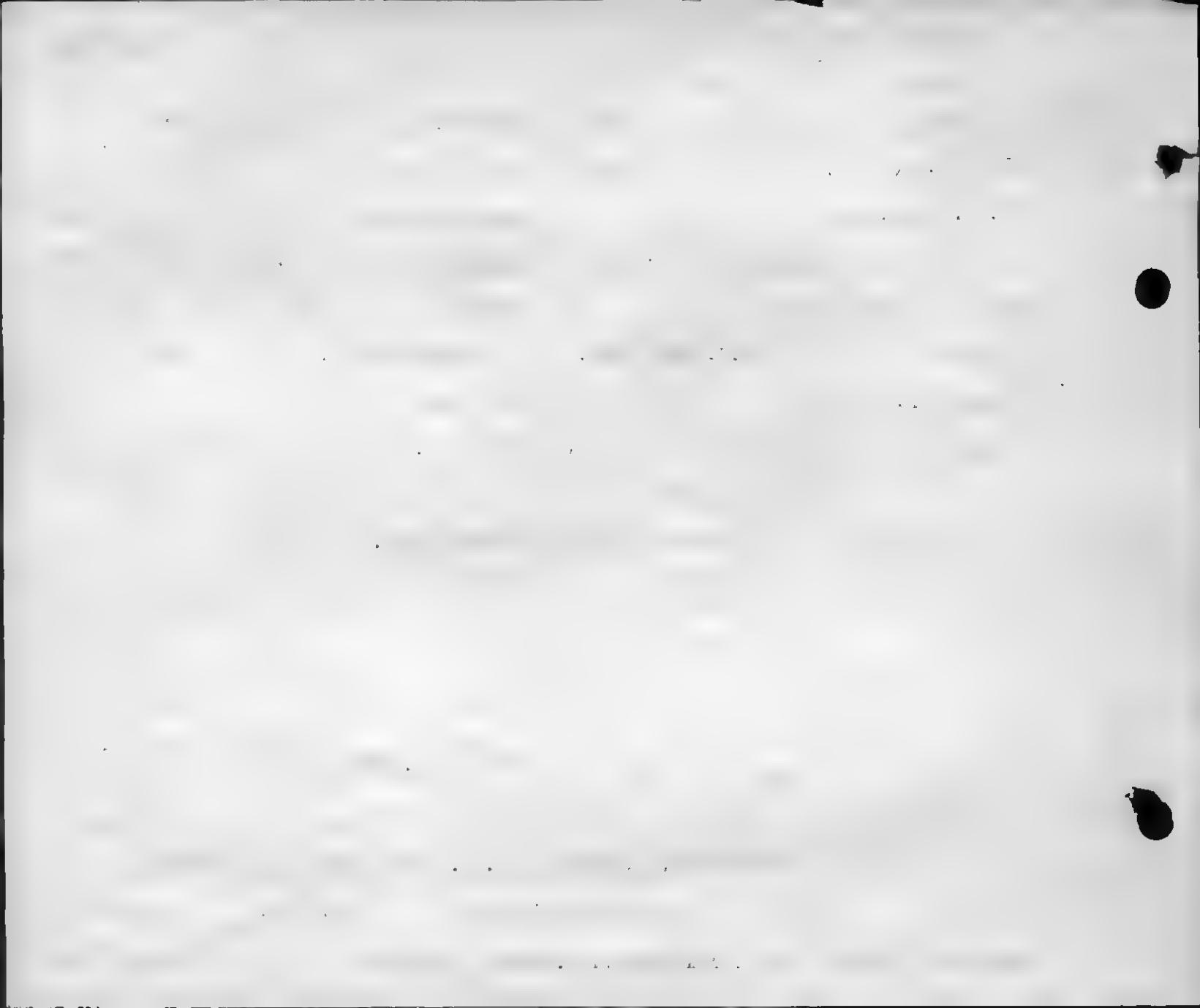
TO HOSPITAL
death, Page 3 be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND c. LENGTH OF STAY IN 7 days		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If out'side corporate limits, write RURAL and give nearest town)	
b. CITY OR TOWN (If out'side corporate limits, write RURAL and give nearest town) Bethesda (Rural)		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		Hyattsville d. STREET ADDRESS 6807 Randolph St.	
3. NAME OF DECEASED (Type or print) Raymond		First M dd's Henry		4. DATE OF DEATH HOOPER June 9 19 61	
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY D.C. Fire Dept.		8. DATE OF BIRTH 2-20-00	
13. FATHER'S NAME William H. HOOPER		11. BIRTHPLACE (Country & State, or foreign country) Washington, D. C.		9. AGE (In years) IF UNDER 1 YEAR last birthday Months Days 61 yrs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or grade of service) Yes WWI		16. SOCIAL SECURITY NO. 577-46-7333		12. CITIZEN OF WHAT COUNTRY? USA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		17. INFORMANT Rosa REECE		Address	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia				INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 495		DUE TO (b) DUE TO (c)			
Pneumonia and Chronic Emphysema.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that <input type="checkbox"/> (this hospital) attended the deceased from June 2 1961 to June 9 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 9 1961 , and that death occurred at <input type="checkbox"/> M, from the causes and on the date stated above.				22b. DATE SIGNED 6-9-61	
22e. SIGNATURE 		M.D. ATTENDING PHYS. <input type="checkbox"/> 22d. ADDRESS		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Paul G. LINWEAVER, LT, MD, USN		U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-13-61		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Arlington National	
24. FUNERAL DIRECTOR'S SIGNATURE 				23d. LOCATION (City, town or county) (State) Arlington Virginia	
				25a. REC'D BY REGISTRAR DATE JUN 13 '61	
				25b. REGISTRAR'S SIGNATURE 	



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

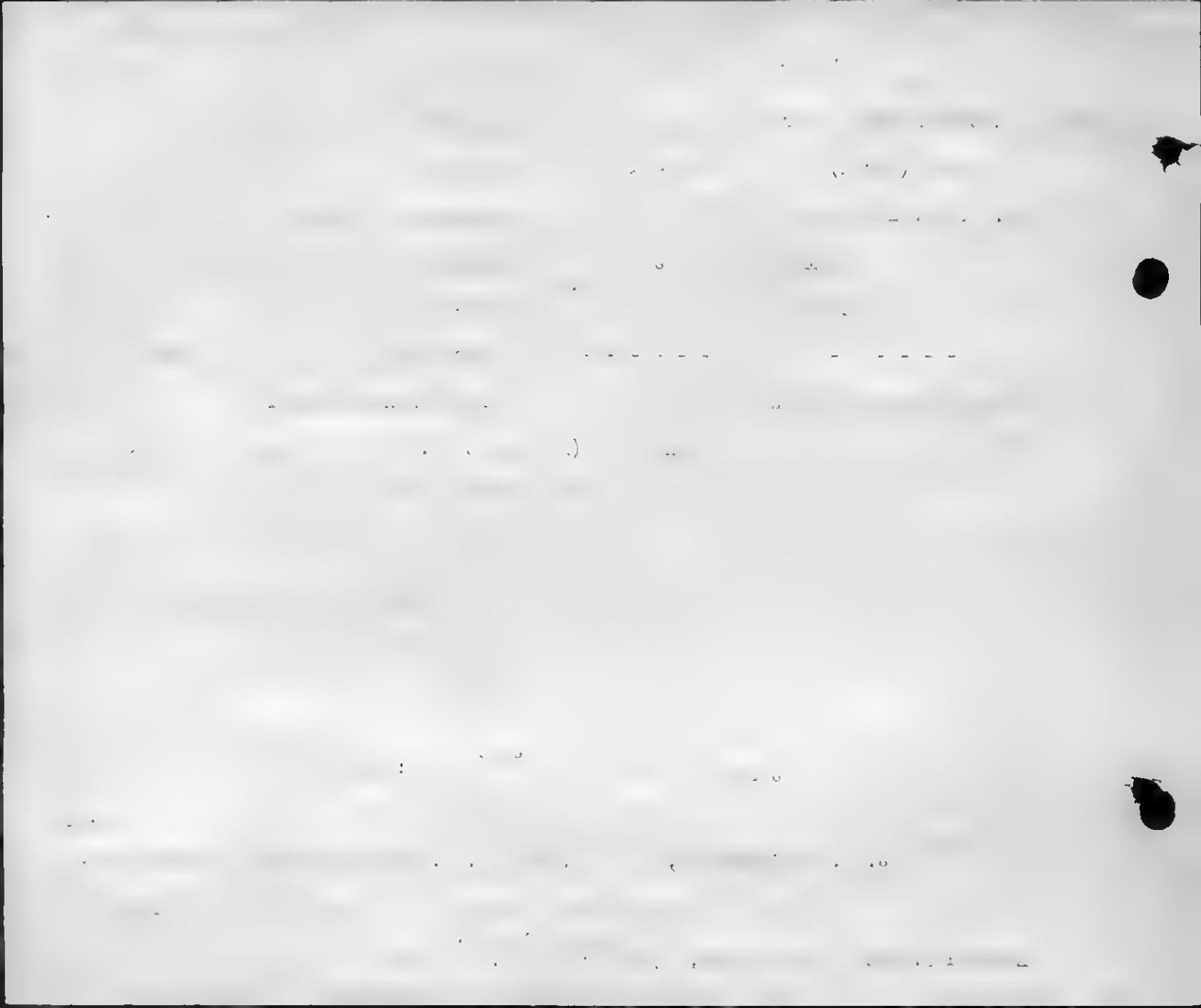
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6947

06934

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 4 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Michael Joseph		4. DATE OF DEATH Last Month Dey Year HOPKINS June 8 1961	
5. SEX Male Caucasian		6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 11-18-59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kenneth Gilman HOPKINS		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Kenneth Gilman HOPKINS		11. BIRTHPLACE (County & State or foreign country) Maryland USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT None (F) Kenneth G. Hopkins, same as #2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. } (b) DUE TO } (c) DUE TO } (c) TRANSMISSION OF GREAT VESSELS		Congenital heart disease (single ventricle, patent ductus arteriosus and pulmonary stenosis with transposition of great vessels)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from _____ to _____, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.		22b. DATE SIGNED 6-9-61	
22c. PHYSICIAN'S NAME (Type) J. E. MC CLENATHAN, CDR, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS New Cathedral Cemetery Baltimore, Md.	
23b. DATE THEREOF 6-12-61		23d. LOCATION (City, town or county) Baltimore Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck Funeral Home, 5303 Harford Rd.		25a. REC'D BY REGISTRAR DATE JUN 13 '61	
		25b. REGISTRAR'S SIGNATURE Charles S. Kline	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 of this certificate should be retained by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6968

CERTIFICATE OF DEATH

06935

1. PLACE OF DEATH

a. COUNTY

MONTGOMERY

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN 1b

5 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

SUBURBAN

3. NAME OF
DECEASED
(Type or print)

First George

Middle SAMUEL

Last HOWARD

4. DATE
OF
DEATH

JUNE 10

1961

5. SEX

Male

6. COLOR OR RACE

Colored

7. MARRIED

NEVER MARRIED

DIVORCED

8. DATE OF BIRTH

11-25-1896

84 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State)

Foreign country

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

GREEN BURY

Howard

MARYLAND

USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT Stonegate ave Rockville, Md.

Address

Harriet C Jenkins (daughter)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

570.2

DEUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

(b)

DEUE TO

(c)

Small Intestinal Obstruction (ileum)

Volvulus of Small Bowel Mesentery

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ 19
p.m. _____

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 6/14/1961 to 6/18/1961, that (I) (we) last saw the deceased alive on 6/9/1961, and that death occurred 5:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

ATTENDING
PHYS.
M.D. MED.
DIRECTOR STAFF
PHYS.
22d. ADDRESS

22b. DATE
SIGNED
6/14/61

Rockville - Md.

23a. BURIAL, CREMATION, DATE THEREOF
REMOVAL (Specify)

6/14/61

23c. NAME OF CEMETERY OR CREMATORIUM

Family Cemetery,

23d. LOCATION (City, town or county)

Unity, Md.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Robert F. Snodden Rockville, Md.

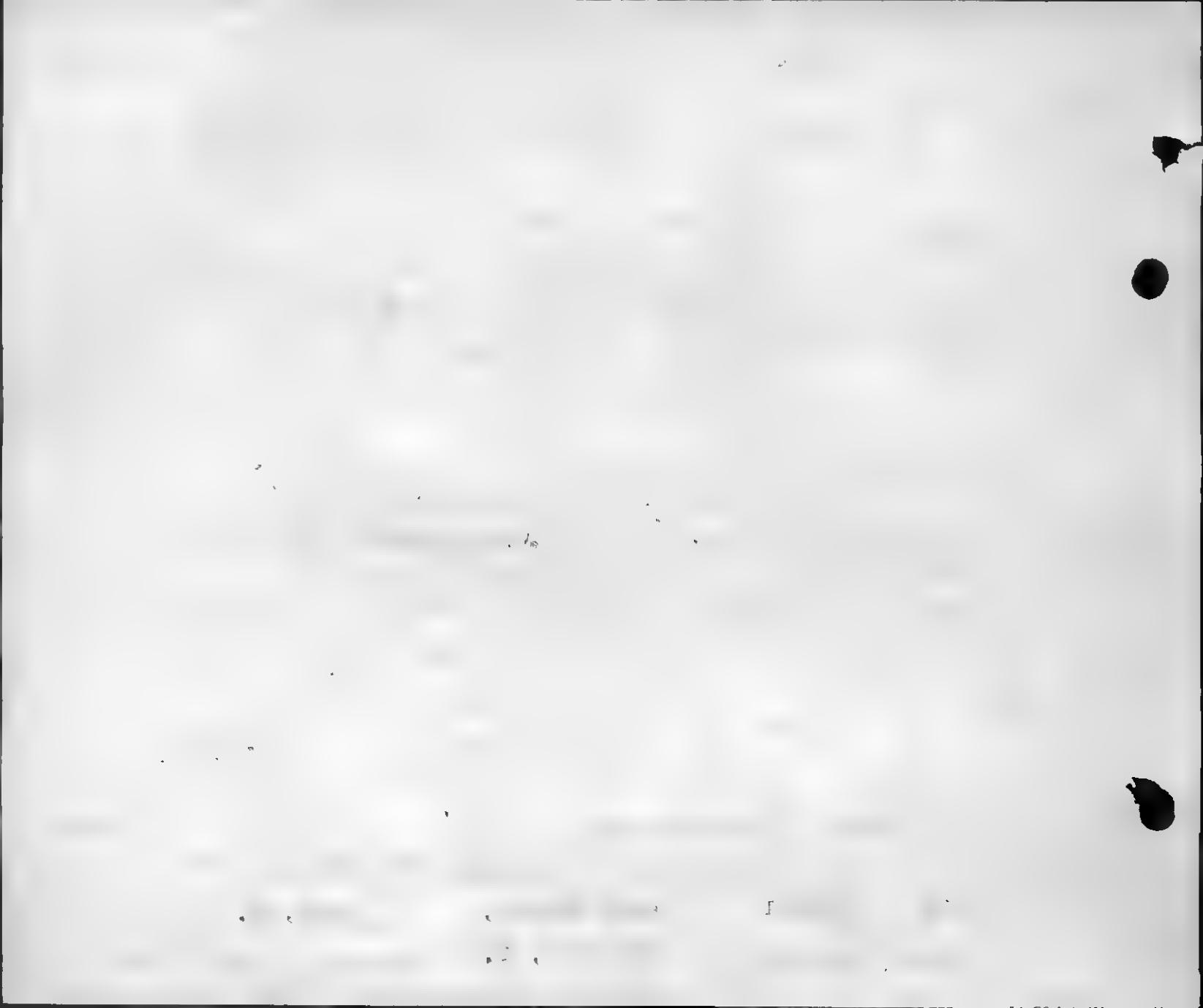
ADDRESS

25a. REC'D BY REGISTRAR

DATE JUN 20 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Krause



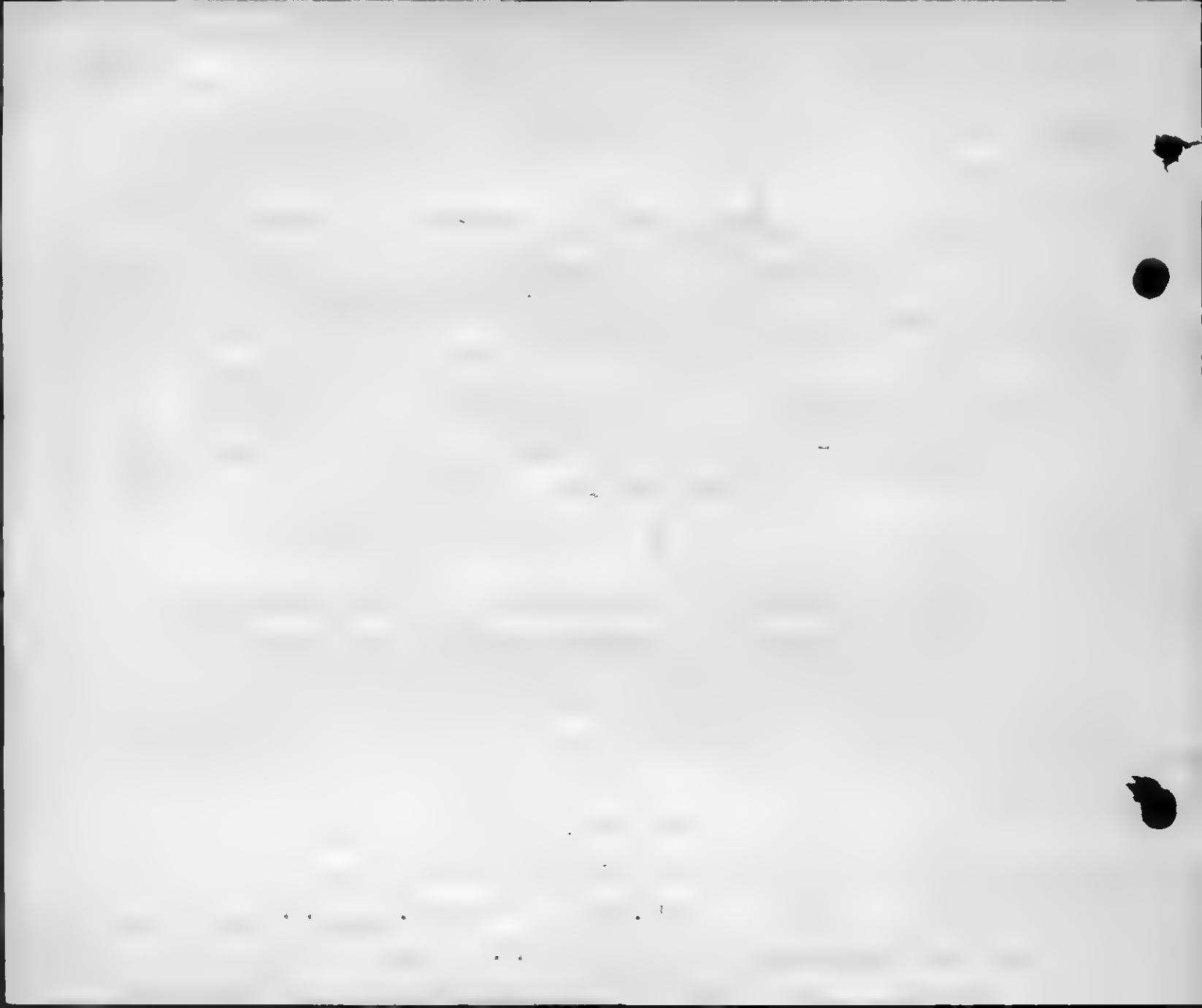
1
FOR STATE
HEALTH DEPT.

M

TO DEPUTY
please execute Affidavit, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY			MONTGOMERY			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Silver Spring			D.C.			a. STATE b. COUNTY		
c. LENGTH OF STAY IN lb						Washington			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			Fairland Nursing Home			1225 Missouri Ave N.W.			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print)			First Dora Middle			Last			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
4. SEX			Female			Inoff			f. DATE OF DEATH 5-1881		
6. COLOR OR RACE			White			g. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. AGE IN yrs last birthday		
7. MARRIED <input type="checkbox"/> NEVER MARRIED						8. DATE OF BIRTH			IF UNDER 1 YEAR Months Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Russia		
13. FATHER'S NAME			H. Grentz			14. MOTHER'S MAIDEN NAME			12. CITIZEN OF WHAT COUNTRY U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)			No			16. SOCIAL SECURITY NO.			17. INFORMANT Idea Mary Address Nursing Home Record		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			Respiratory failure			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO 321X			Cerebral vascular accident			INTERVAL BETWEEN ONSET AND DEATH 1/2 day		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b)			DUE TO						2 weeks		
			(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fracture left big toe home about 3 yrs ago			20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> p.m. Not While at work <input type="checkbox"/>			20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			Frank J. Borschart			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			DATE SIGNED 6-1-61		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 6/2/1961			22c. NAME OF CEMETERY OR CREMATORIAL Nat'l. Capital Hebrew Cemetery			22d. LOCATION (City, town, or country) D.O.		
23. FUNERAL DIRECTOR Goldberg Funeral Home			ADDRESS 4217 9th Street N.W.			24a. REC'D BY REGISTRAR DATE JUN 5 '61			24b. REGISTRAR'S SIGNATURE Albert S. Kline		





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
6950			06937								
1. PLACE OF DEATH a. COUNTY		MARYLAND									
Montgomery		GERMANTOWN									
b. CITY OR TOWN (If outside corporate limits, give rural and give nearest town)		c. LENGTH OF STAY IN lb									
Germantown		1 mo									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Collins Rd - Box 186									
Collins Rd - Box 186		Collins Rd - Box 186									
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month Day Year	
Louise A. Jackson								June 1		1961	
5. SEX		6. COLOR OR RACE		7. MARRIED		NEVER MARRIED		8. DATE OF BIRTH		9. AGE (in years last birthday) IF UNDER 1 YEAR	
Female		White		<input checked="" type="checkbox"/>		<input type="checkbox"/>		9-28-1871		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY									
Housewife		11. BIRTHPLACE (State or foreign country)									
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
Michael Lutz		Hannah ?									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> If yes give name and date of service		16. SOCIAL SECURITY NO.		17. INFORMANT		714 Woodburn Rd., Rockville, Md.		Address			
No		None		Mrs Joseph G. Brown							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
420.1 DUE TO Coronary occlusion											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)											
DUE TO											
} (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m.		Month Day Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Frank J. Bloschert</i>											
EXAMINER'S NAME (Type) <i>FRANK J. BLOSCHELT</i>											
22a. BURIAL, CREMATION, REMOVAL (Specify) Transit		22b. DATE THEREOF 6/2/61		22c. NAME OF CEMETERY OR CREMATORIUM Dunmore		22d. LOCATION (City, town, or county) Scranton, Pennsylvania		(State)			
23. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Md.											
ADDRESS											
24a. REC'D BY REGISTRAR DALE JUN 5 '61											
24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>											



Item 18 Film 290 7-3-61 MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

FOR STATE
 HEALTH DEPT.

M

If any delay is necessary,
 please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
 a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN FB

5 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Suburban

3. NAME OF
 DECEASED
 (Type or print)

First

Middle

Last

Charles

Salyer

Jennings

4. DATE
 OF
 DEATH

Month

Day

Year

June

19

1961

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

Nov. 24, 1915

9. AGE (in years
 last birthday)

45 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Editor

10b. KIND OF BUSINESS OR INDUSTRY

U.S. News & World Report

11. BIRTHPLACE (State or foreign country)

Colorado

13. FATHER'S NAME

Charles

Jennings

14. MOTHER'S MAIDEN NAME

Jane Salyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

No

16. SOCIAL SECURITY NO.

Yes

17. INFORMANT

Unknown

Pauline Jennings (wife) Same as above

Address

INTERVAL BETWEEN
 ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a)

Spontaneous thrombosis of pulmonary, coronary

& cerebral arteries

Conditions, if any, which
 gave rise to immediate cause
 (a), stating the underlying
 cause last.

(b) Acute Thrombocytosis following splenectomy

DUE TO

(c) rupture of spleen from accidental fall

DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
 PERFORMED?
 YES NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
 PRIMARY OR CONTRIBUTING CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Fell from house roof at home

20c. TIME OF INJURY Month, Day, Year
 Hour a.m.

10:00 p.m. 6-17 1961

20d. INJURY OCCURRED
 While Not While
 at work at work

20e. PLACE OF INJURY (Home, farm,
 factory, street, office bldg., etc.)

20f. (City or town)
 (County) (State)

home

Cherry Chase Drivt. Md

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
 death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

6-19-61

ACTUAL
 SIGNATURE

Frank J. Bloschert

EXAMINER'S
 NAME (Type)

FRANK J. Bloschert

Address (Street, city, town, or county)

22a. BURIAL, CREMATION,
 REMOVAL (Specify)

Burial

22b. DATE THEREOF

6/22/61

22c. NAME OF CEMETERY OR CREMATORIUM

Parklawn Cemetery

22d. LOCATION (City, town, or country)

Rockville, Maryland

(State)

23. FUNERAL DIRECTOR

Robert A. Pumphrey

ADDRESS

Bethesda, Maryland

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

JUN 22 '61

Charles S. Kraus

Oct. 10 - 1968 - 10:30

1000' E. of

1000'

TO HOSPITAL OR HOSPITAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after the death. It may be retained by the hospital or attending physician.

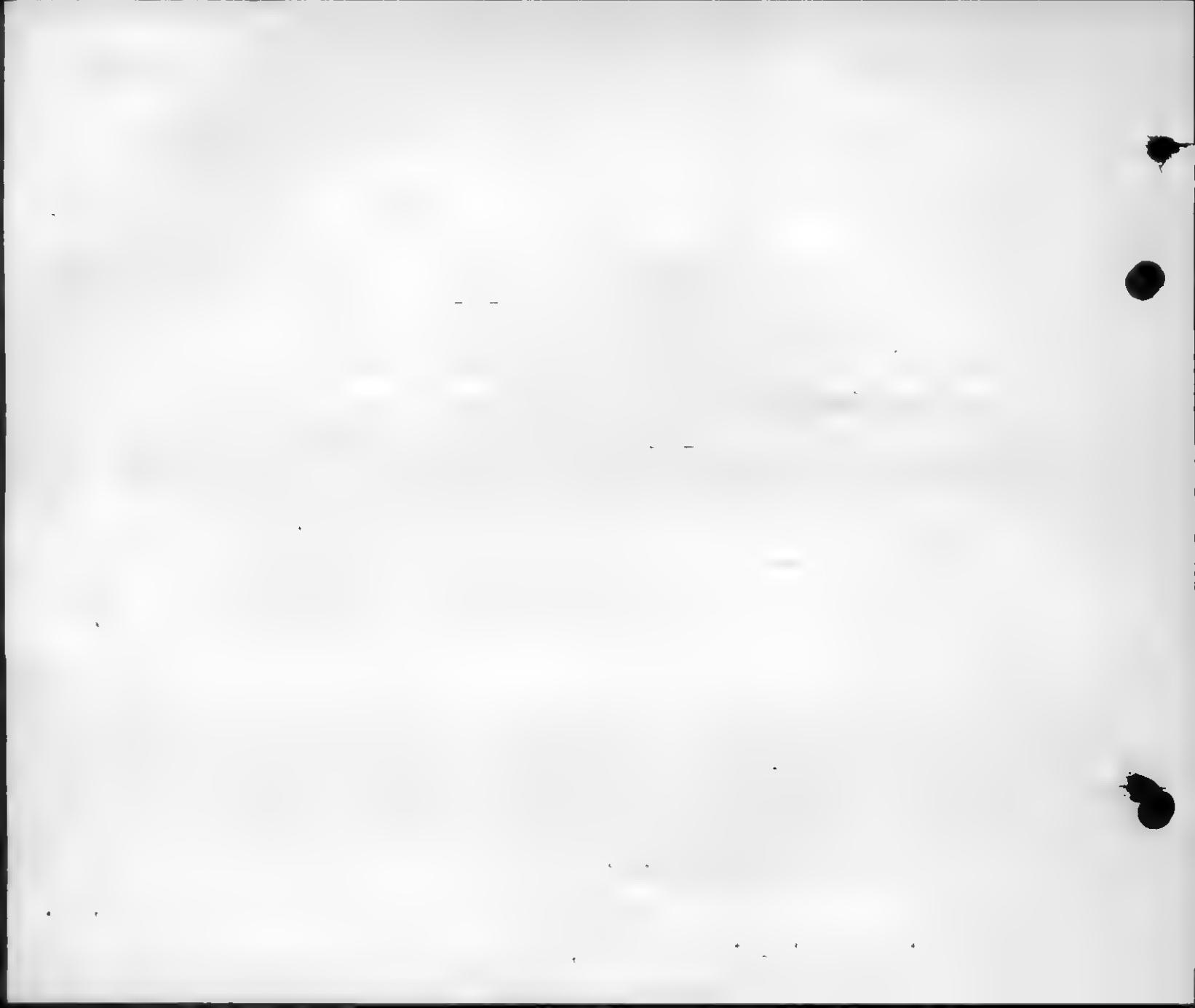
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE		06939				
MONTGOMERY MARYLAND		MARYLAND						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c LENGTH OF STAY IN 1b 16 HOURS		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		d STREET ADDRESS 15500 GOOD HOPE ROAD		
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL						e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) MARGARET		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
				JOHNSON	JUNE	13,		19 61
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 4-10-82	9. AGE (In years lost birthday) 79 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Andrew Jackson HARDING				14. MOTHER'S MAIDEN NAME Rebecca Myers				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 219-34-8156		17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO (b) PERFORATION OF Common Duct (c) HYPERTENSIVE HEART DISEASE				INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 10 DEC. 1960, to 13 JUNE 1961, that (II) (we) last saw the deceased alive on 13 June 1961, and that death occurred at 11 PM, from the causes and on the date stated above								
22a. SIGNATURE John Bosley Ziegler		22b. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22d. ADDRESS		22b. DATE SIGNED 6/14/61		
22c. PHYSICIAN'S NAME (Type) JOHN B. ZIEGLER, M.D.								
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF 6/16/61		23c. NAME OF CEMETERY OR CREMATORIAL Burtonsville Union Cemetery		23d. LOCATION (City, town, or county) (State) Burtonsville, Montgomery, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE Warren E. Pumphrey, Inc.		ADDRESS 8434 Georgia Avenue Silver Spring, Maryland		25a. REC'D BY REGISTRAR DATE JUN 16 '61		25b. REGISTRAR'S SIGNATURE Lillian E. House		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6953

06940

CERTIFICATE OF DEATH

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		b. COUNTY <i>Montgomery</i>			
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington San F. Hospital</i>		d. STREET ADDRESS <i>6631 Eastern Ave</i>			
e. NAME OF DECEASED (Type or print) <i>Anna</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Anna</i>	Middle <i>MARIE</i>	Last <i>Jokumsen</i>		
4. DATE OF DEATH	Month <i>June</i>	Day <i>27</i>	Year <i>1961</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>12-10-72</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Postal Service</i>			
11. BIRTHPLACE (County & State, or foreign country) <i>Denmark</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>			
13. FATHER'S NAME <i>Mads Jokumsen</i>		14. MOTHER'S MAIDEN NAME <i>Karen Maria Nelson</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. 17. INFORMANT <i>Hospital Records</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>UREMIA</i> 44 SX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>HYPERTENSIVE CARDIOVASCULAR DISEASE</i> (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CONGESTIVE HEART FAILURE					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> While at work p.m. <input type="checkbox"/> Not While at work 19		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) <input type="checkbox"/> (State) <input type="checkbox"/>	
21. I certify that (I) <i>(his hospital)</i> attended the deceased from 17 JUNE , 1961, to 23 JUNE , 1961, that (I) <i>(we)</i> last saw the deceased alive on 26 JUN E , 1961, and that death occurred at 7:45 AM , from the causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE <i>Morrill C. Quinnam Jr.</i>		22b. DATE SIGNED <i>6-27-61</i>			
22c. PHYSICIAN'S NAME (Type) <i>MORRILL C. QUINNAM, JR.</i>		22d. ADDRESS <i>704 Newsham Road Takoma Park Md.</i>			
23a. BURIAL, CREMATION, DATE THEREOF REMOVAL (Specify) <i>Cremation June 29, 1961</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Alexandria Cemetery</i>		23d. LOCATION (City, town or county) <i>Washington D.C.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters, 254 Carroll St NW 10C</i>		ADDRESS <i>Arthur Walters, 254 Carroll St NW 10C</i>		25a. REC'D BY REGISTRAR DATE JUN 30 '61	
25b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>					



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6954

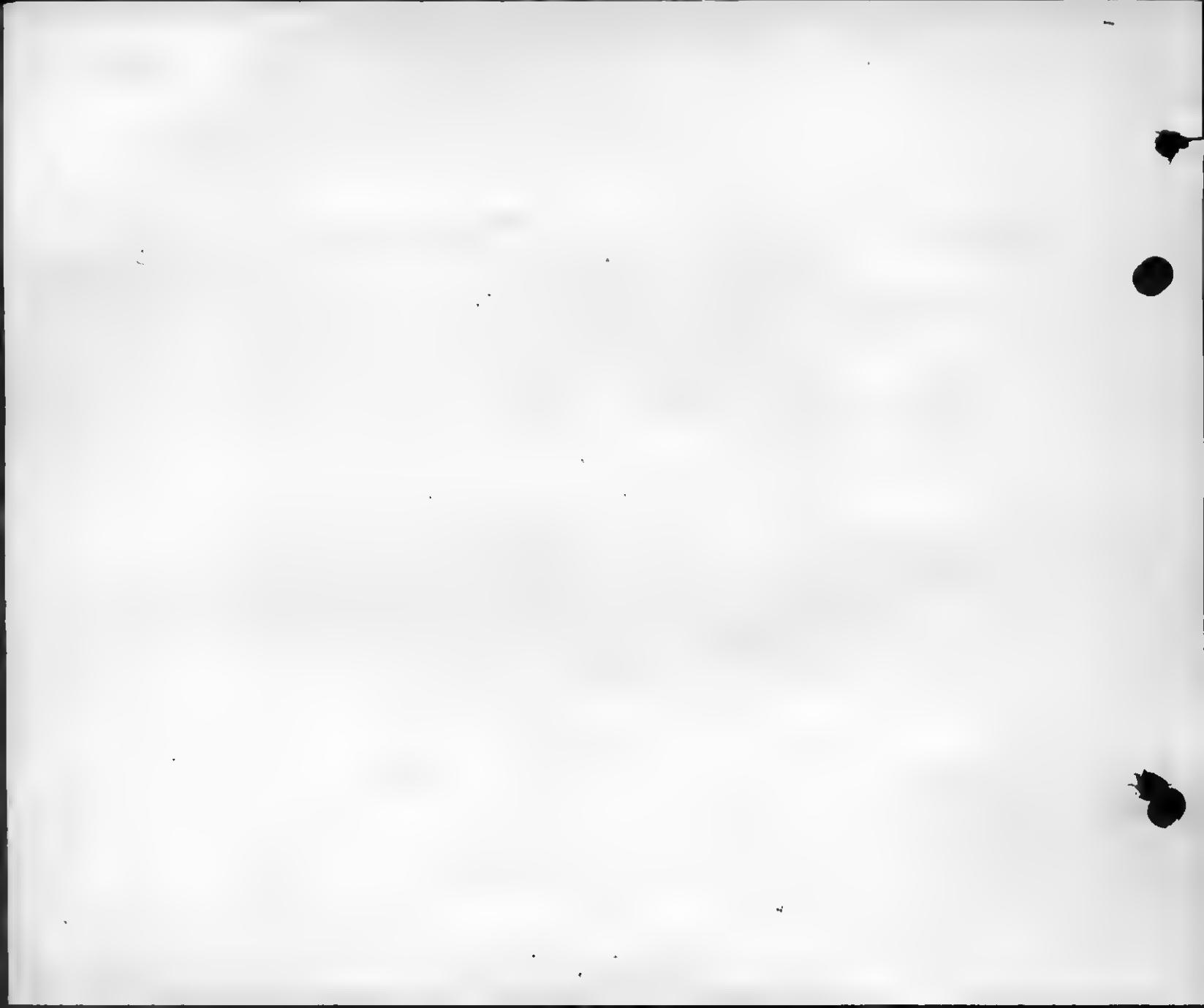
06941

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the attending physician or attending physician. After this certificate has been signed by the attending physician, it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/59

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN TB 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Germantown				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				d. STREET ADDRESS Route #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Betty		First	Middle	Last	4. DATE OF DEATH 6	Month	Day	Year 13 1961
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/27/02		9. AGE (In years last birthday) 58 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min. 11. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Hammond		14. MOTHER'S MAIDEN NAME Betty Ann Heaton						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Henry B. Wheeler / Jane Mrs. Abner		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ix DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 3 days		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <u>W</u> (this hospital) attended the deceased from <u>6/12</u> 19 <u>61</u> to <u>6/13</u> 19 <u>61</u> that <u>N</u> (we) last saw the deceased alive on <u>6/12</u> 19 <u>61</u> and that death occurred at <u>9451 Rockwell</u> from the causes and on the date stated above.								
22a. SIGNATURE <u>H.C. Wheeler</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/13/61</u>				
22c. PHYSICIAN'S NAME (Type) <u>H.C. Wheeler</u>		22d. ADDRESS <u>Rockwell Building, Rockville</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/15/61		23c. NAME OF CEMETERY OR CREMATORY Parklawn		23d. LOCATION (City, town, or county) Rockville, Montgomery, Md. (State)		
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home		ADDRESS 1331 E. Montg. Ave Rockville, Maryland		25a. REC'D. BY REGISTRAR JUN 19 '61		25b. REGISTRAR'S SIGNATURE Clyde S. Thomas		



HOSPITAL OR HOMING PHYSICIAN: The law requires that the death certificate be executed
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6955			06942		
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Hosp. & Sant.			d. STREET ADDRESS 1519--White Pl., S.E.		
3. NAME OF DECEASED (Type or print) First LAURA Middle PECK Last JONES			4. DATE OF DEATH Month June Day 1st Year 19 61		
5. SEX 6. COLOR OR RACE Female White		7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED DIVORCED		8. DATE OF BIRTH Feb. 8, 1884	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Boardin; Home		11. BIRTHPLACE (State or foreign country) Pa.	
13. FATHER'S NAME Galusha A. Peck			14. MOTHER'S MAIDEN NAME Susan Mertz		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Frank S. Peck 1519--White Pl SE Wash. DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Due To Cerebral thrombosis Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis Due To Years (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Large bed sores malnutrition					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) May 26, 1961, to June 1, 1961, that we last saw the deceased alive on June 1, 1961, and that death occurred at 6125Amp			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work Not while at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 26, 1961, to June 1, 1961, that we last saw the deceased alive on June 1, 1961, and that death occurred at 6125Amp the causes and on the date stated above					
22a. SIGNATURE Norman H. Rubenstein			22b. DATE SIGNED 6/1/61		
22c. PHYS. C.A.N.S. NAME (Type) Norman H. Rubenstein, M.D.			22d. ADDRESS 6480 N.H. Ave., Takoma Park, Md.		
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF June 3, 1961		23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery	
24. FUNERAL DIRECTOR'S SIGNATURE Simon Bros.			ADDRESS 1661--Good Hope Rd., SE Washington 20 DC		
25a. REC'D BY REGISTRAR DATE JUN 5 '61			25b. REGISTRAR'S SIGNATURE C. L. Lewis		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6955

CERTIFICATE OF DEATH

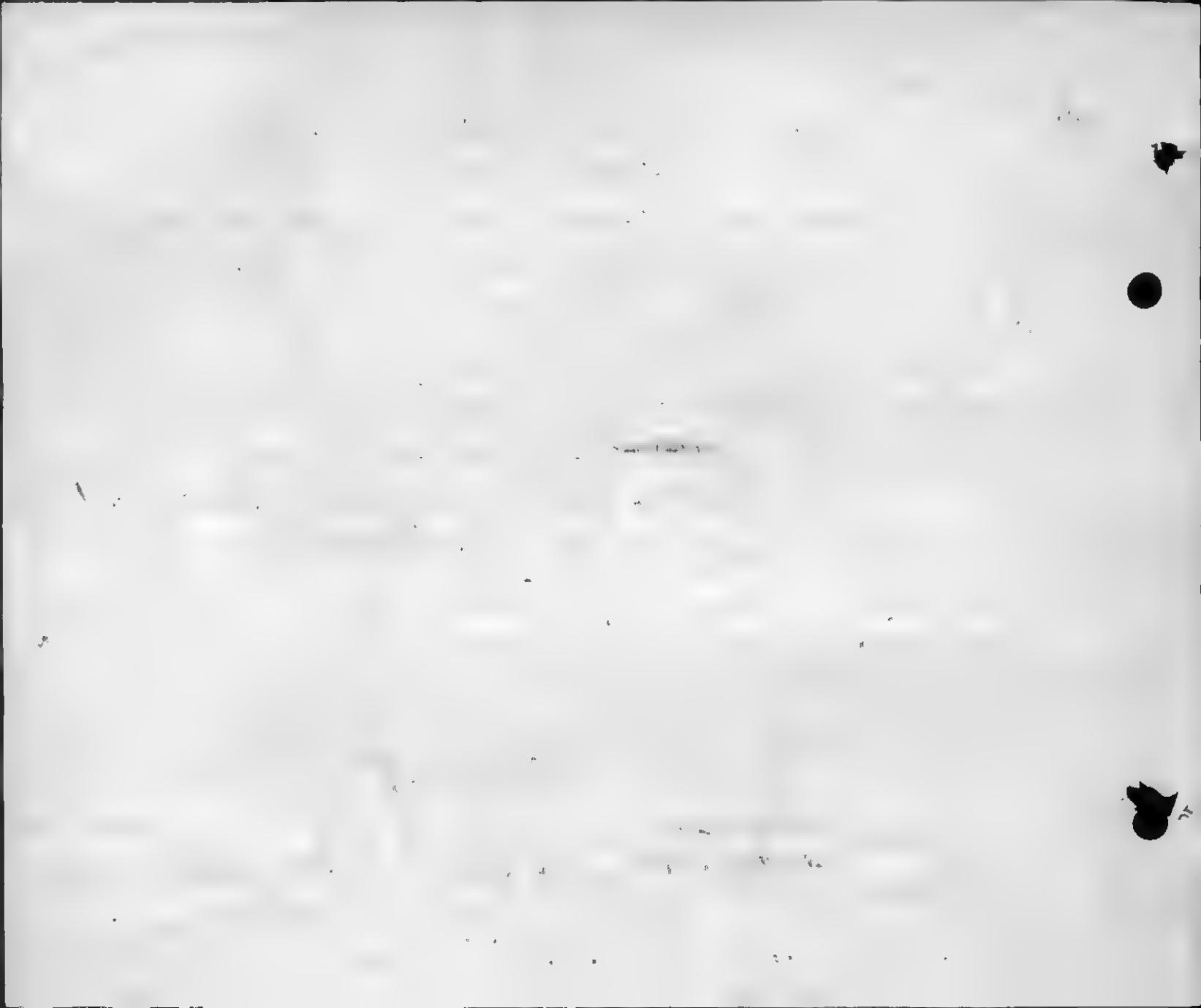
60544

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

YR A15 (4)
15M 9/60

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		b. COUNTY DISTRICT OF COLUMBIA	
c. LENGTH OF STAY IN 1b 30 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium and Hospital		d. STREET ADDRESS 1868 Columbia Rd. N.W.	
3. NAME OF DECEASED (Type or print) Ola Elizabeth Jost		4. DATE OF DEATH Last Month Day Year July 3 1961	
5. SEX F		6. COLOR OR RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 7-14-86	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Amer.	
13. FATHER'S NAME William F. Morris		14. MOTHER'S MAIDEN NAME Lettitia Longfellow	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/>		16. SOCIAL SECURITY NO. 577-16-2933	
17. INFORMANT No		18. CAUSE OF DEATH (Enter only one cause or line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Vascular ulcer - Right lower leg	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Cardiac failure (Acute Decompensation) 1 Day Cardio-Vascular-Renal Syndrome 2 wks.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e. (City or town) (County) (State) May 1 1961 to June 3 1961	
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, and that death occurred at _____ A.M. from the causes and on the date stated above.		21. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
22a. SIGNATURE lynwood heiges		22b. DATE SIGNED June 3, 1961	
22c. PHYSICIAN'S NAME (Type) lynwood heiges		22d. ADDRESS 6990 Linley Branch Rd. N.W.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 6/5/61	
23c. NAME OF CEMETERY OR CREMATORIAL Prospect Hill Cemetery		23d. LOCATION (City, town or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.		25a. REC'D BY REGISTRAR ADDRESS Wash. D.C.	
		25b. REGISTRAR'S SIGNATURE DATE JUN 5 '61 Arthur S. Hines	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

0957

CERTIFICATE OF DEATH

06945

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

I

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>D.C.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>7 1/2 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Saburbian Hospital</i>		e. STREET ADDRESS <i>6641 32nd Street NW</i>	
f. FIRST MIDDLE LAST <i>Annie Malkin Joyce</i>		g. DATE OF DEATH <i>June 20 1961</i>	
h. SEX <i>Female</i>		i. COLOR OR RACE <i>White</i>	
j. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		k. DATE OF BIRTH <i>Dec 9 1871</i>	
l. AGED (In years last birthday) <i>89 yrs.</i>		m. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
n. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		o. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
p. BIRTHPLACE (County & State, or foreign country) <i>Connecticut</i>		q. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
r. FATHER'S NAME <i>Joseph Malkin</i>		s. MOTHER'S MAIDEN NAME <i>? Emily Cady</i>	
t. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give war or date of service) <i>No</i>		u. SOCIAL SECURITY NO. 17. INFORMANT <i>James Wallace Joyce (Son)</i>	
v. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i> DUE TO <i>Myocardial infarction</i>		w. INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i>	
x. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Myocardial infarction</i>		y. INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i>	
z. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
aa. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		bb. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
cc. TIME OF INJURY Hour a.m. p.m. 19		dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
ee. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		ff. (City or town) (County) (State)	
gg. I certify that (I) (this hospital) attended the deceased from <i>June 14 1961</i> to <i>June 19 1961</i> , that (I) (we) last saw the deceased alive on <i>June 19 1961</i> , and that death occurred at <i>6 A.M.</i> from the causes and on the date stated above.			
hh. SIGNATURE <i>R Raedy MD</i>			
ii. PHYSICIAN'S NAME (Type) <i>R Raedy MD</i>		jj. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> kk. ADDRESS <i>3701 Loland St Silver Spring Md</i>	
ll. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		mm. DATE THEREOF <i>6-20-61</i>	
nn. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Crematory</i>		oo. ADDRESS <i>Bethesda, Md.</i>	
pp. LOCATION (City, town or county) <i>Prince George Co., Md.</i>		qq. REC'D BY REGISTRAR DATE <i>JUN 22 1961</i>	
rr. FUNERAL DIRECTOR'S SIGNATURE <i>ROBERT A. PUMPHREY</i>		ss. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

4

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6958

CERTIFICATE OF DEATH

06946

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington San. & Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
3. NAME OF DECEASED (Type or print) James Wilson Kendall		d. STREET ADDRESS 4019 5th St. N. W.	
5. SEX Male		e. DATE OF DEATH June 27 1961	
6. COLOR OR RACE White		f. AGE (In years last birthday) 75 yrs	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		g. IF UNDER 1 YEAR Months Days 12 months	
WIDOWED <input type="checkbox"/>		h. IF UNDER 24 HRS Hours Min. 1 hour	
D VORCED <input type="checkbox"/>		i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motorman - Streetcar		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Virginia	
13. FATHER'S NAME Robert Buchanan		14. MOTHER'S NAME Isadora C. Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give rank or date of service)		16. SOCIAL SECURITY NO. 1578-10-6246	
17. INFORMANT no		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Diabetes mellitus	
		DUE TO (b) Hypertension	
		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Wheaton (County) Maryland (State) MD	
21. I certify that (I) (this hospital) attended the deceased from May 6 1961 to June 27 1961 , that (I) (we) last saw the deceased alive on June 24 1961 , and that death occurred at Wheaton , from the causes and on the date stated above.			
22e. SIGNATURE A. W. Smith		22b. DATE SIGNED 6/27/61	
22c. PHYSICIAN'S NAME (Type) A. W. SMITH		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 13018 GEORGIA AVE WHEATON, MD.	
23e. BURIAL, CREMATION, REMOVAL (Specify) Burial		23f. DATE THEREOF 6/30/61	
23g. NAME OF CEMETERY OR CREMATORIAL Glenwood Cemetery		23h. LOCATION (City, town or county) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.		25a. REC'D BY REGISTRAR JUN 29 '61	
		25b. REGISTRAR'S SIGNATURE Clinton S. Thomas	



51
FOR STATE
HEALTH DEPT.
M

TO DEPUTY: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the Certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6959

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06947

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
a. COUNTY		b. STATE	
Montgomery		Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Silver Spring		Silver Spring	
1021 Forest Glen Rd		1021 Forest Glen Rd	
First Middle		Last	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
Katherine Elizabeth Kester		June 15 1961	
5. SEX		6. COLOR OR RACE	
Female		White	
7. MARRIED		8. DATE OF BIRTH	
Never Married		7-12-1894	
WIDOWED		9. AGE IN YEARS (At birthday)	
DIVORCED		IF UNDER 1 YEAR	
		Months	Days
		Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Homemaker		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
41-S.C.		Benj. Phillips	
14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)	
Elis. Graham		No	
16. SOCIAL SECURITY NO.		17. INFORMANT	
579-16-4488A		Wm. H. Kester -	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 526X		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		sudden	
(b)		year	
DUE TO		Acute congestive heart failure	
(c)		Bronchitis	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		Address (Street, city, town, or county)	
22f. DATE THEREOF 6/18/61		22d. LOCATION (City, town, or country)	
22c. NAME OF CEMETERY OR CREMATORIUM Mt View		(State)	
23. FUNERAL DIRECTOR ADDRESS		24e. REC'D BY REGISTRAR	
Ed Hartzer & Son Union Bridge, Md		24f. REGISTRAR'S SIGNATURE	
VS. AISMES SM 9/60		DATE JUN 19 '61	



1
FOR STATE
HEALTH DEPT.
TO FUNERAL DIRECTOR: Please execute the Certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ-3. Page 5 may be retained for your files.

M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06948

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Clarksburg

c. LENGTH OF STAY IN 1b

MARYLAND

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Johnson Rd.

3. NAME OF
DECEASED
(Type or print)

First

Middle

Brewer

John

King

4. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

WIDOWED

DIVORCED

Sept. 7, 1890

70

Last

4. DATE
OF
DEATH

June 23

Month

Day

1961

Year

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Carpenter

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

13. FATHER'S NAME

John B. King

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank, dates of service)

Yes

WW # 1

16. SOCIAL SECURITY NO.

212-14-5755

17. INFORMANT

Mrs Elizabeth P. King

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause first. (b)

DUE TO

(c)

Coronary occlusion

Item 2

INTERVAL BETWEEN
ONSET AND DEATH
Sudden

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
EXTERNAL or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

19. WAS AUTOPSY
PERFORMED?
YES NO

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes Accident , Suicide , Homicide , Undetermined manner

ACTUAL SIGNATURE *Frank J. Broschart* CHIEF MEDICAL EXAMINER

EXAMINER'S NAME (Type) Frank J. Broschart ASSISTANT MEDICAL EXAMINER

DATE SIGNED

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

June 23, 1961
(State)

Burial June 27, 1961

Arlington National

Fort Myer, Va.

23. FUNERAL DIRECTOR

Olin L. Molaworth

ADDRESS

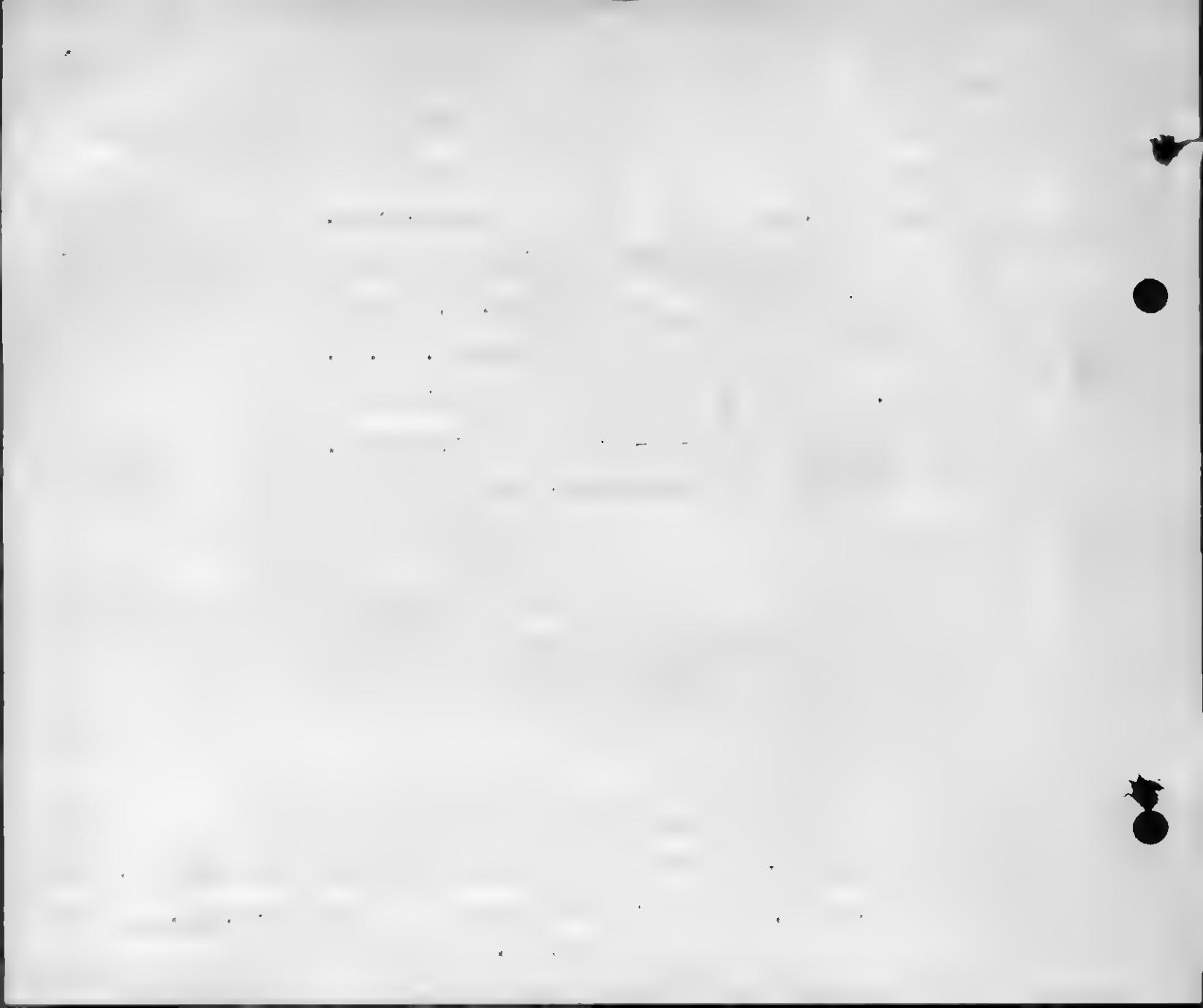
Damascus, Md.

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

JUN 27 '61

Arthur S. Hayes



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6961

CERTIFICATE OF DEATH

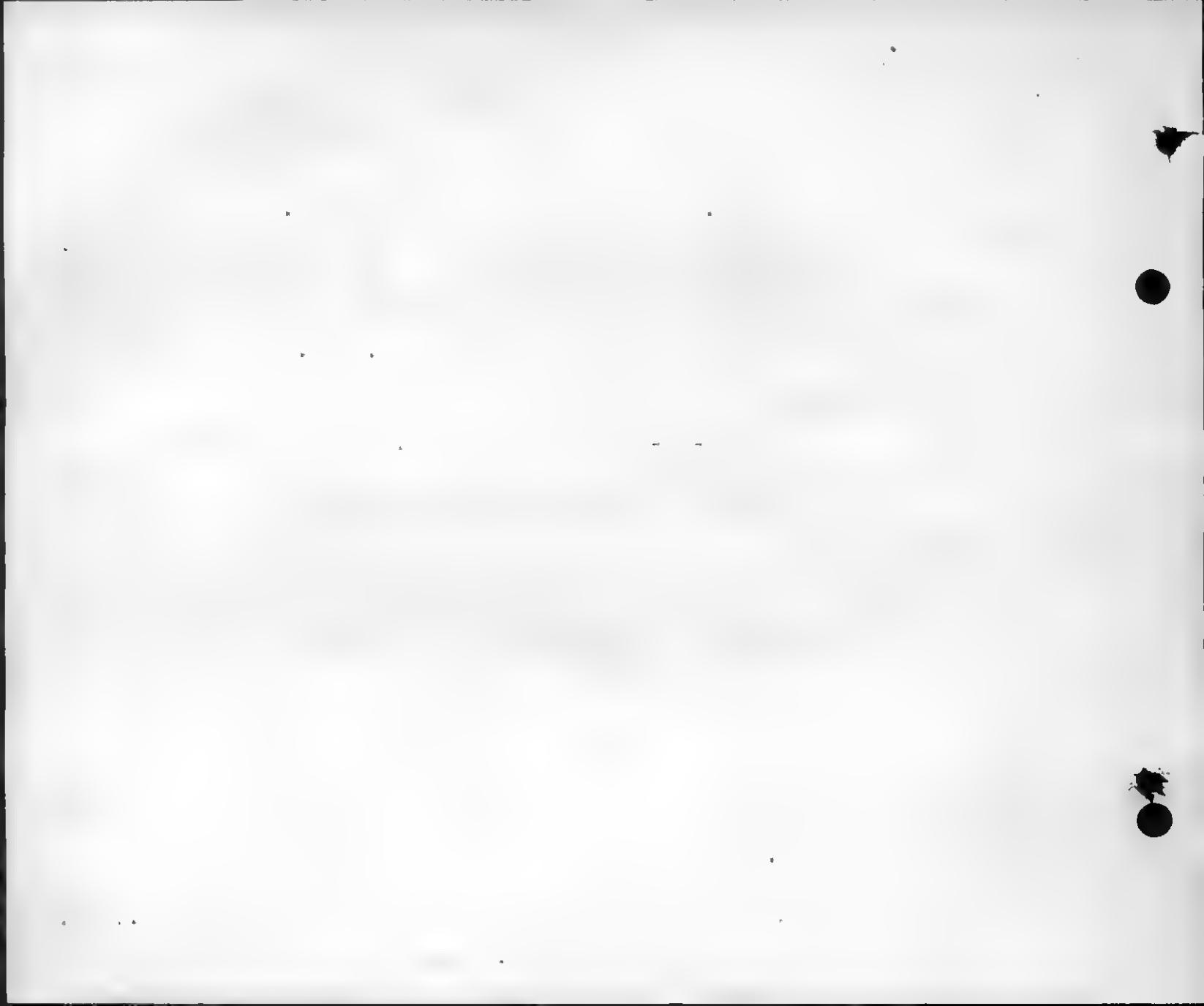
Reg. Dist. No. 6949

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9703 Beall Ave.			e. STREET ADDRESS 9703 Beall Ave.							
3. NAME OF DECEASED (Type or print) Myrtle Barton Klawonn			First Myrtle	Middle Barton	Last Klawonn					
4. DATE OF DEATH June 9 1961	Month June	Day 9	Year 1961							
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, 1884	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Hours 0	Days 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Fulton Co., Pa.				
13. FATHER'S NAME Samuel Slayman			14. MOTHER'S MAIDEN NAME Mary Hill			12. CITIZEN OF WHAT COUNTRY? USA				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. (If yes, give war or dates of serv.) 220-07-4711			INFORMANT Mrs Harry B. Merson, Item 2			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. { (b) DUE TO (c)			PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH 10 years.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 619			20f. (City or town) (County) (State) 619	
21. I certify that I attended the deceased from 5/17 , 19 58 to 6/19 , 19 61 , that I last saw the deceased alive on 6/4 , 19 61 , and that death occurred at M. from the causes and on the date stated above. ACTUAL SIGNATURE James P. Kerr M.D.									ADDRESS (Street, city or town, state) Damascus, Md.	
PHYSICIAN'S NAME (Type) James P. Kerr									DATE SIGNED 6/9/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial June 12, 1961		22b. DATE THEREOF June 12, 1961		22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln			22d. LOCATION (City, town, or county) Prince Georges Co., Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Woburn		ADDRESS Damascus, Md.			24a. REC'D BY REGISTRAR DATE JUN 13 '61		24b. REGISTRAR'S SIGNATURE Cynthia S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death by a physician or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal; and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal; and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B



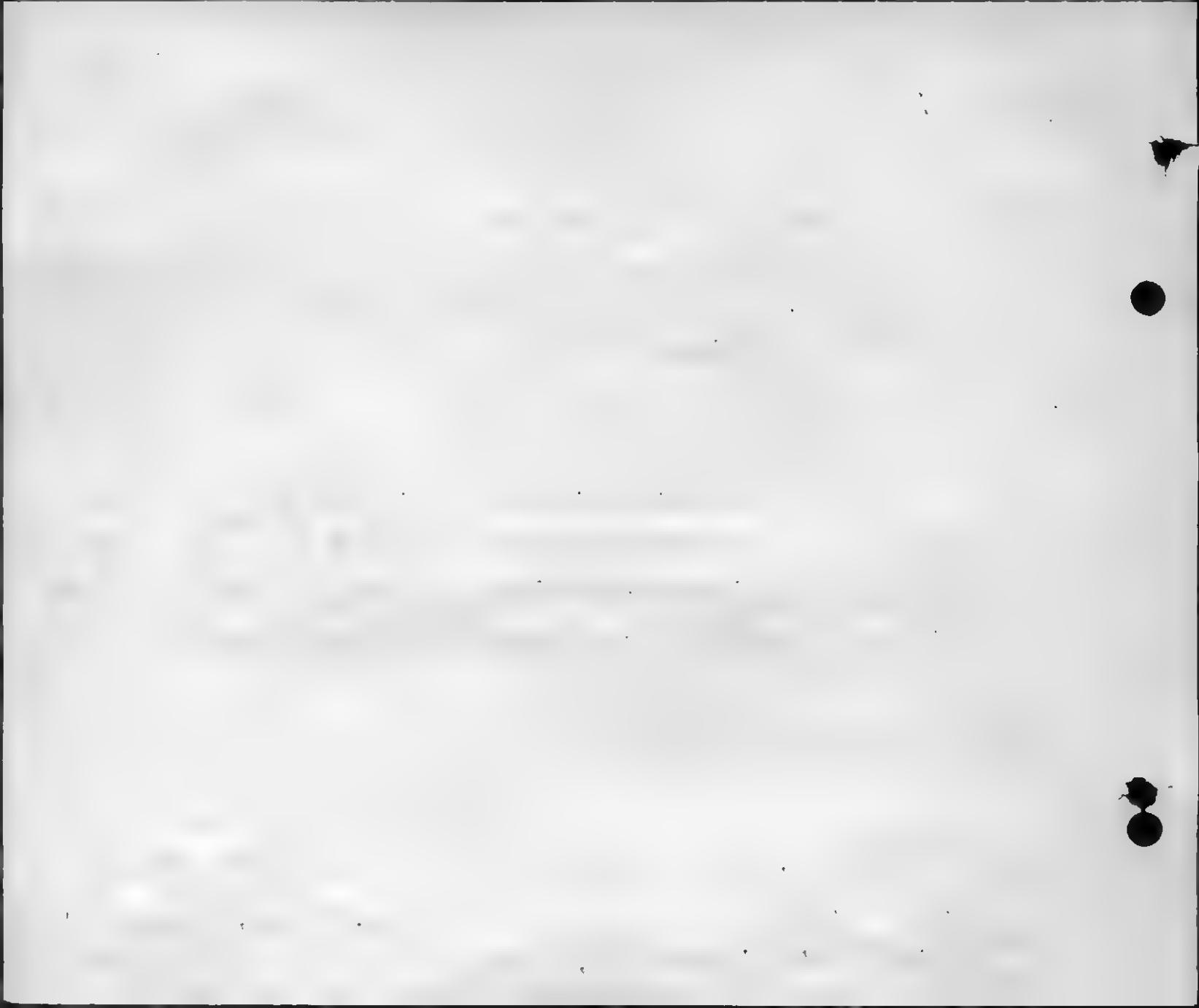
TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06950

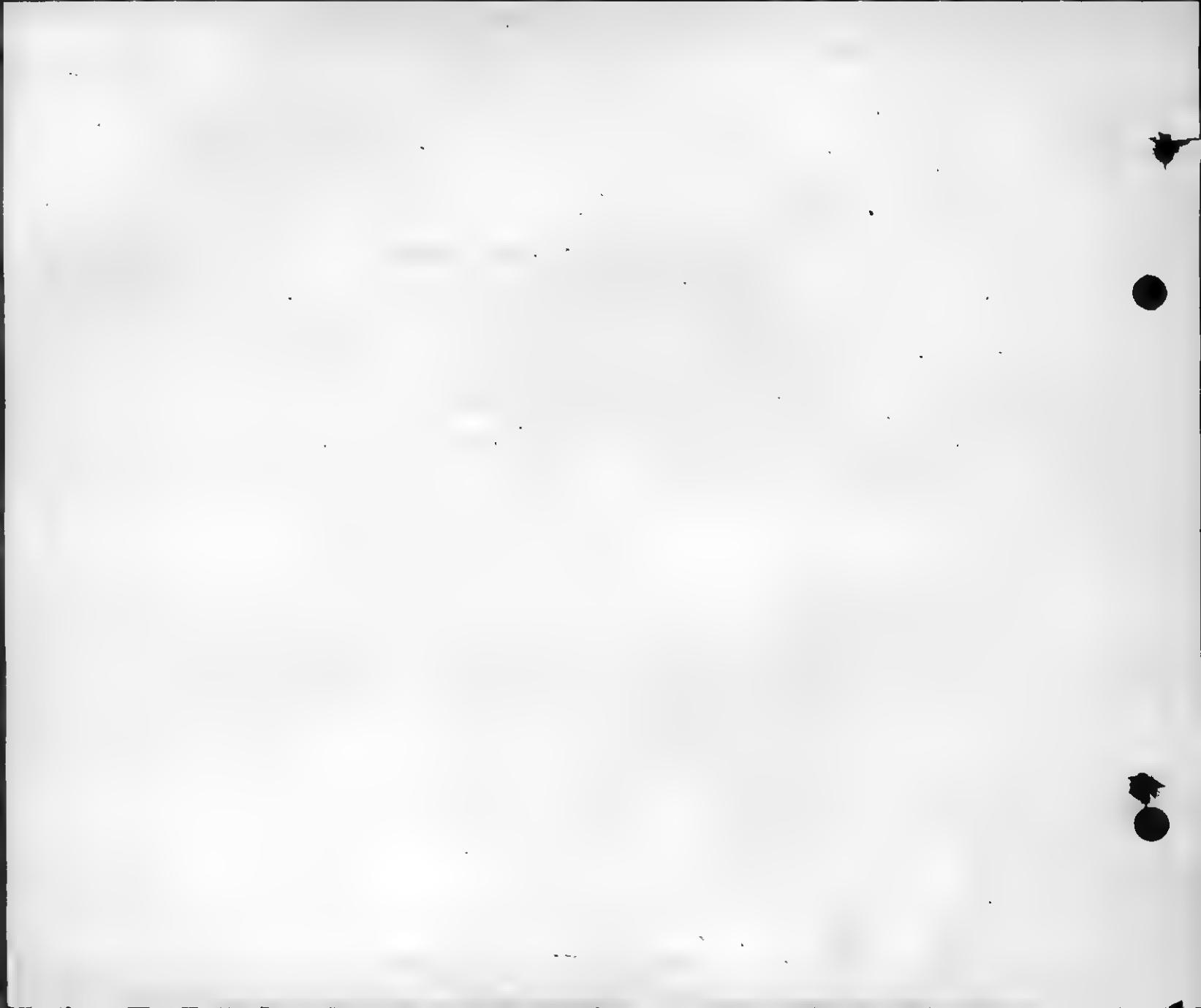
1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b 10 days		d. STREET ADDRESS Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium & Hosp. 9407 Biltmore Dr. I		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frederick Joseph Klund		First	Middle
4. DATE OF DEATH June 8 1961		Month	Day
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 8-12-87		9. AGE (in years last birthday) 73 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Bureau of Internal Revenue	
11. BIRTHPLACE (County & State, or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? Amer.	
13. FATHER'S NAME David H. Klund		14. MOTHER'S MAIDEN NAME Georganna Josephine Chart	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary infarction and severe pulmonary edema		DUE TO left lung	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443X		DUE TO Hypertensive heart disease with left ventricular hypertrophy	
		DUE TO Right lung, upper lobe, early acute bronchopneumonia	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(a)			
Six days postoperative for resection of adenocarcinoma of the colon			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) (If either, notify medical examiner)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1961 to June 7, 1961 , that (I) (we) last saw the deceased alive on June 7, 1961 , and that death occurred at 6:15 A.M. from the causes and on the date stated above.		22b. DATE SIGNED June 8-61	
22e. SIGNATURE George H. McLain,		22d. ADDRESS 1746 K St. N.W. Wash. D.C.	
22e. PHYSICIAN'S NAME (Type) GEORGE H. McLAIN		22f. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/12/61	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Washington National Cemetery, Suitland, Prince George's - Warner E. Pumphrey Inc. 8434 Georgia Avenue Mayfield Station Silver Spring, Maryland		23d. LOCATION (City, town or county) Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey Inc.		25e. REC'D BY REGISTRAR JUN 14 1961	
		25b. REGISTRAR'S SIGNATURE Charles S. Krause	



6963

06951

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Montgomery				a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Takoma Park		3 days		Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS	
Washington Sanitorium & Hospital				1356 University Blvd. E.	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
Phillip			NMN	KRAUTWURST	JUNE 19 1961
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
Male	White				12-11-1880
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min	
80					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Construction Worker				Hungary	
12. CITIZEN OF WHAT COUNTRY?				U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address	
Adam Krautwurst		Dorothy Burman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No				Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO 181.0 INTERVAL BETWEEN ONSET AND DEATH 3-4 days					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Carcinoma of the Urinary Bladder 1 month					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19					
21 I certify that (I) (this hospital) attended the deceased from June 19, 1961, to June 19, 1961, that (I) (we) last saw the deceased alive on June 19, 1961, and that death occurred at M, from the causes and on the date stated above					
22a. SIGNATURE Robert B. Tracy			22b. DATE SIGNED		
M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS 7103 Riggs Rd., Hyattsville, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23d. LOCATION (City, town, or county)	
Burial		June 22-61		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR DATE JUN 21 '61	
J. Arthur Walters, 254 Carroll St NW, D.C.				25b. REGISTRAR'S SIGNATURE William S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

66952

1. PLACE OF DEATH
COUNTYMontgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Takoma Park

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington Sanitarium and Hospital

3. NAME OF
DECEASED
(Type or print)

First Herman

Middle Henry

Last Ladson

5. SEX

6. COLOR OR RACE

Male

white

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Veterinarian

13. FATHER'S NAME

Thomas A. Ladson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank, dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

(Part I) DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

5271

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause test.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY
Hour a.m. Month, Day, Year
p.m. 1920d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from...
saw the deceased alive on... and that death occurred at... from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
(Name & Type)23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial23b. DATE THEREOF
6-16-61

24. FUNERAL DIRECTOR'S SIGNATURE

Francis D. Barber Laytonsville, Md.

23c. NAME OF CEMETERY OR CREMATORIAL
Rock Creek Cemetery
ADDRESS

23d. LOCATION (City, town or county)

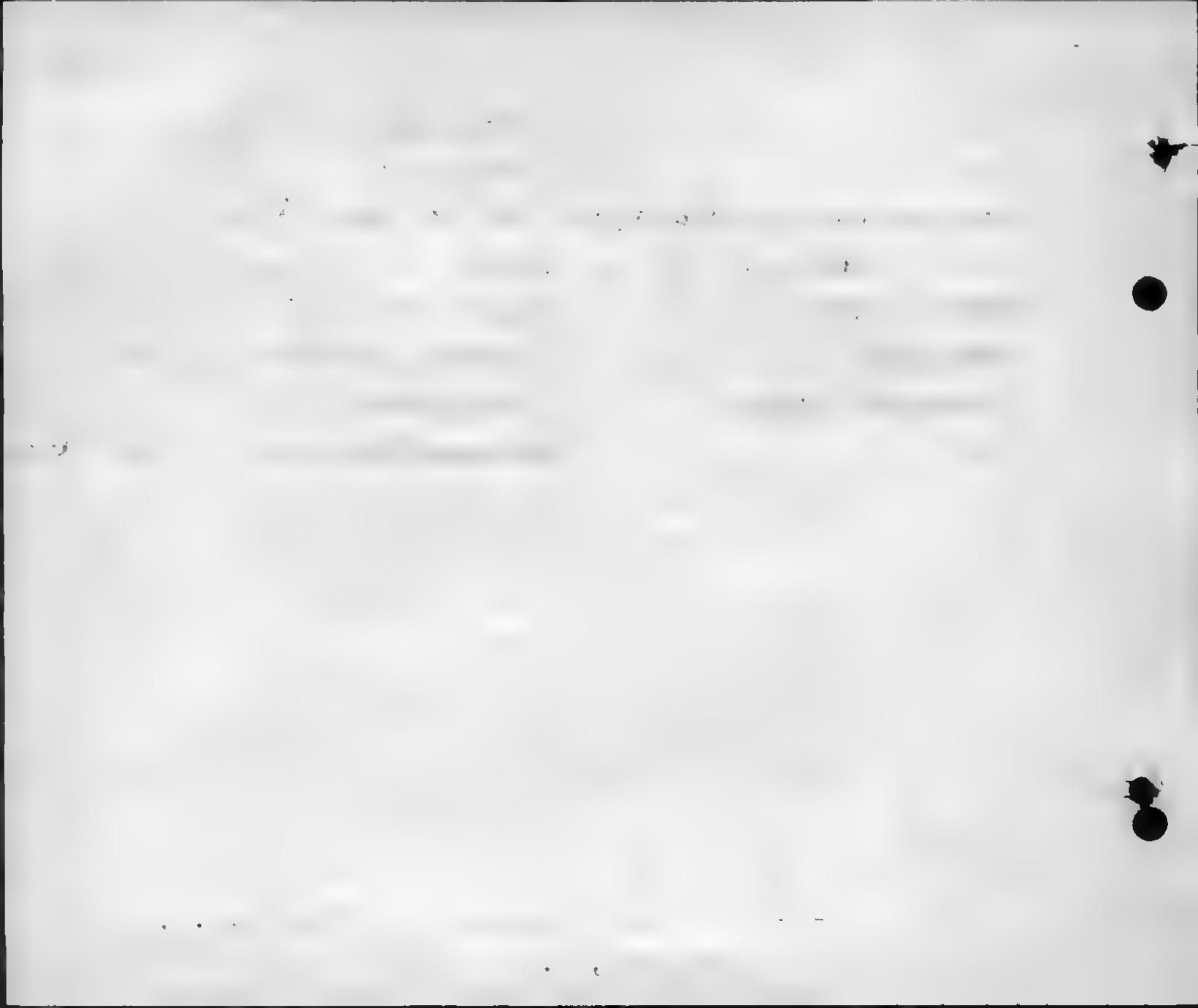
(State)

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.

22d. ADDRESS

22b. DATE
SIGNED25e. REC'D BY REGISTRAR
DATE JUN 19 '6125b. REGISTRAR'S SIGNATURE
Arthur S. Kraus



HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 10 to be retained by the physician or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6965 CERTIFICATE OF DEATH

06953

1. PLACE OF DEATH
a. COUNTY

MONTGOMERY

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

SILVER SPRING

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

8718 CAMERON STREET apt. 218

3. NAME OF
DECEASED
(Type or print)

First

Middle

MILDRED PEABODY LAIRD

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

ATC. 8, 1884

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

13. FATHER'S NAME

GEORGE H. PEABODY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

NO

16. SOCIAL SECURITY NO. | 17. INFORMANT

013-20-1060 B Robert P. Laird, West Vancouver, Canada

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last

(b)

DUE TO

(c)

Congestive failure of heart
Multiple, widespread metastatic malignancy
Mixed mesodermal tumor of uterus

INTERVAL BETWEEN
ONSET AND DEATH

1 hr.

6-8 weeks

6 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m. While at work Not While at work
p.m. 19

20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov 1, 1960, to June 24, 1961, that (I) (we) last saw the deceased alive on 24 June 1961, and that death occurred at 11:00 A.M. from the causes and on the date stated above.

22a. SIGNATURE

Ernest E. Harmon

22b. DATE SIGNED

JUNE 24, 1961

22c. PHYSICIAN'S NAME (Type) ERNEST E. HARMON

M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

22d. ADDRESS

9301 Colesville Rd. Silver Spring, Md.

23a. BURIAL, CREMATION
REMOVAL (Specify)
CREMATION

23b. DATE THEREOF JUNE 24, 1961

23c. NAME OF CEMETERY OR CREMATORIAL

FORT LINCOLN CREMATORIAL

23d. LOCATION (City, town or county) PRINCE GEORGE'S COUNTY, MD.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

WADDELL & HARRIS, INC., SILVER SPRING, MD.

ADDRESS

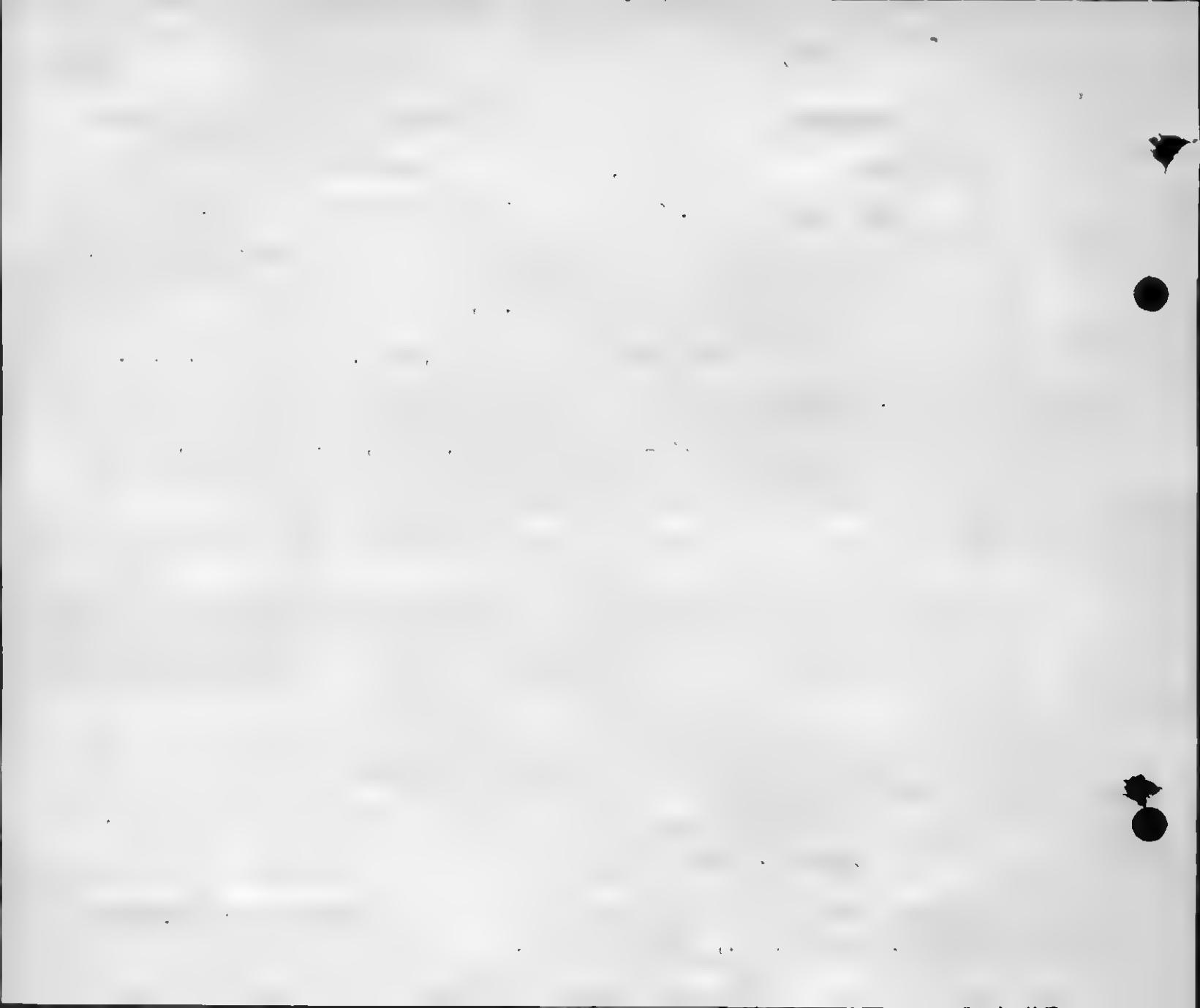
Raymond A. Ziska

25a. REC'D BY REGISTRAR DATE JUN 27 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Mann

VR A15 (4)
15M 9/60



TO HOSPITAL may be referred to hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

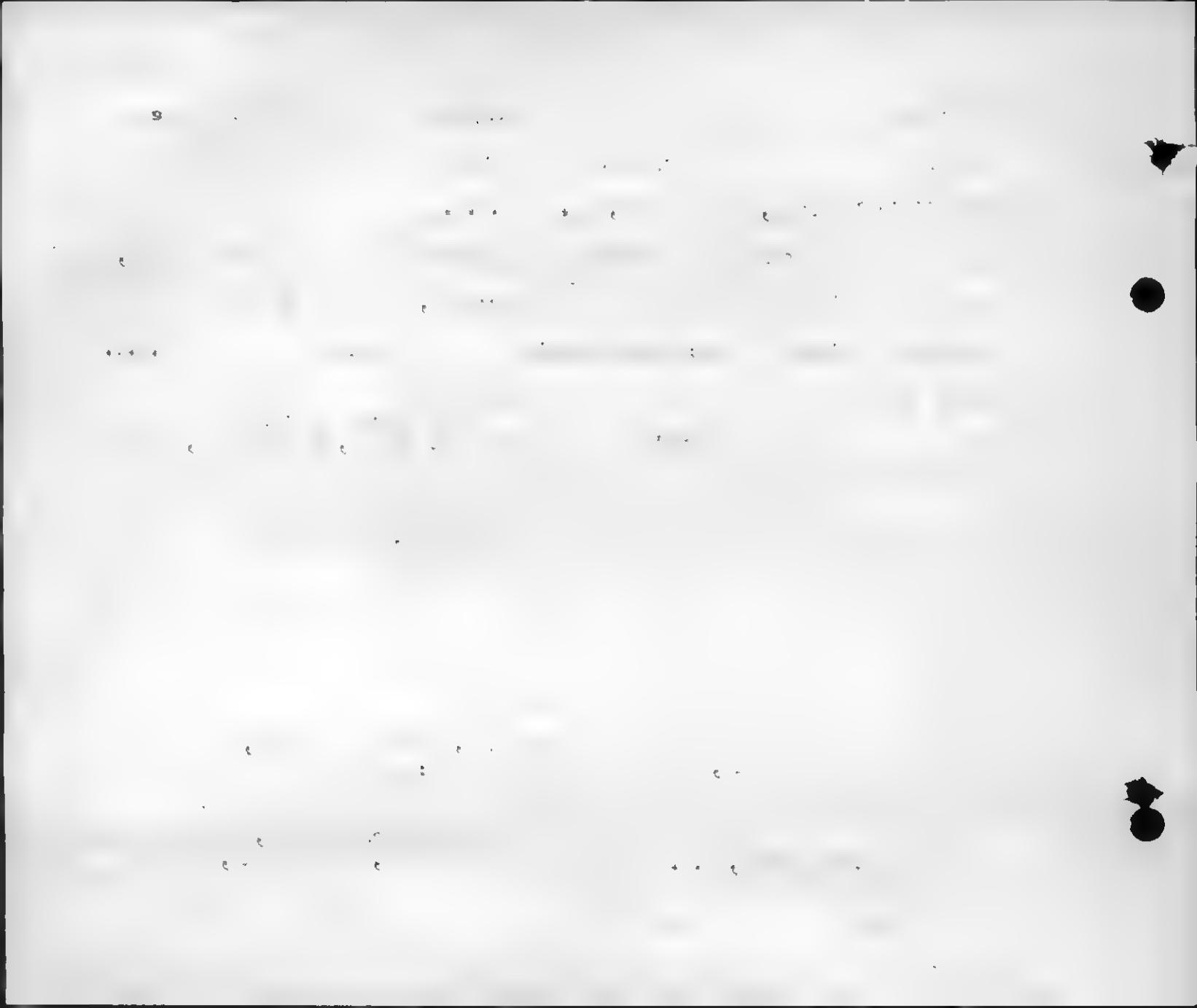
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05
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6954

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 67 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		d. STREET ADDRESS R.F.D. 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First John	Middle Henry	Last Lamers	4. DATE OF DEATH March 25, 1896	Month June	Day 12	Year 1961
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1896	9. AGE (In years last birthday) 65 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0
10a. JSUAL OCCJPAION (Give kind of work done during most of working life, even if retired) Truck body builder		10b. KIND OF BUSINESS OR INDUSTRY Truck manufacturing		11. BIRTHPLACE (State or foreign country) Maryland		12. CIT ZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Lamers		14. MOTHER'S MAIDEN NAME Annie Otten					
15. WAS DECEASED EVER IN J. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. Unavailable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) <i>Septicemia</i> DUE TO (c) <i>Disseminated Cerebrations of unknown primary site</i>						INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) April 6, 1961		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 12, 1961 , to June 12, 1961 , that (I) (we) last saw the deceased alive on June 12, 1961 , and that death occurred 3:00 AM from the causes and on the date stated above.							
22a. SIGNATURE <i>Walter Oppelt</i>		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>				22b. DATE SIGNED 6-12-61	
22c. PHYSICIAN'S NAME (Type) WALTER OPPELT, M.D.		22d. The Clinical Center, National Institutes of Health, Bethesda 14, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial June 15, 1961, St Marys Cem		23b. DATE THEREOF June 15, 1961		23c. NAME OF CEMETERY OR CREMATORIAL St Marys Cem		23d. LOCATION (City, town, or county) Laurel Md	
24. FUNERAL DIRECTOR'S SIGNATURE DeWitt Donaldson, Laurel, Md.		ADDRESS DeWitt Donaldson, Laurel, Md.		25a. REC'D BY REGISTRAR DATE JUN 19 '61		25b. REGISTRAR'S SIGNATURE Charles S. Greene	



1
FOR STATE
HEALTH DEPT.



TO DEPUTY
please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

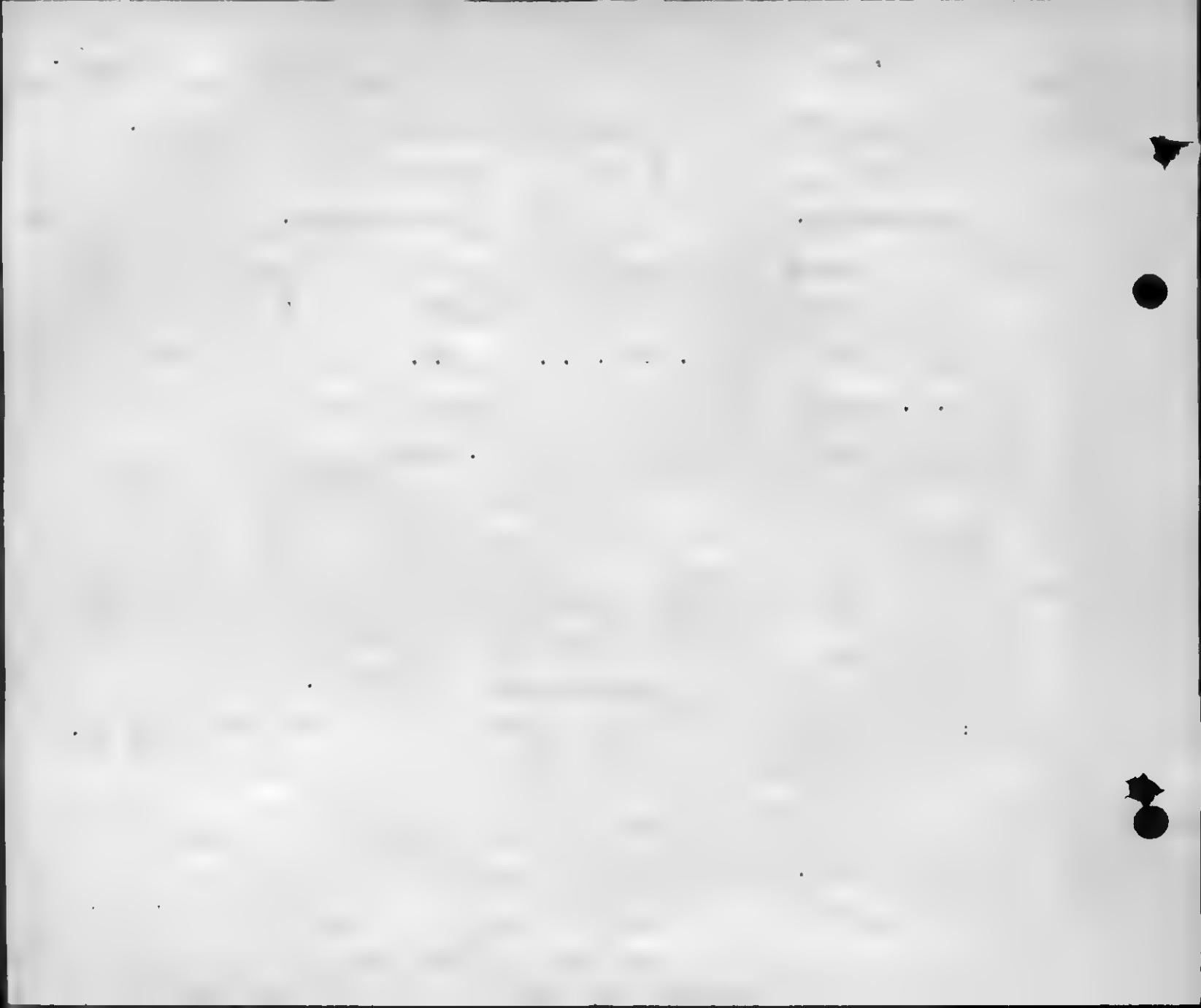
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6967

0C955

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
Montgomery		c. LENGTH OF STAY IN lb		a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		11 days		b. COUNTY Montg.	
Bethesda				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				Silver Sprng	
Suburban Hosp.				d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		First	Middle	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Theresa Grace Langbein				Day Year	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH	Month	
female white		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	3/2/1874	19 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min.	
cashier (ret)		Dept. store, D.C.		87 yrs.	
13. FATHER'S NAME		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Geo. A. Langbein		D.C.		USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
No		577-05-3579			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Hosp. Record			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute myocardial infarct			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) } } DUE TO		Thrombosis, left descending coronary			
} (c) } } DUE TO		Atherosclerotic coronary			
} PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture rt. hip with fracture 16-18 June '61		INTERVAL BETWEEN ONSET AND DEATH 36 hours			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		36 hours			
20c. TIME OF INJURY Month, Day, Year Hour <input checked="" type="checkbox"/> p.m. 4:30 6/16/61		20d. INJURY OCCURRED While <input type="checkbox"/> Not White <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) home Silver Spring Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 6/27/61			
EXAMINER'S NAME (Type) Frank J. Broschart					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 7-1-61		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Wash. D.C.	
Burial				22d. LOCATION (City, town, or county) Washington, D.C.	
23. FUNERAL DIRECTOR				(State)	
F.J. Collins 3821-14 NW D.C.				24a. REC'D BY REGISTRAR DATUM 30 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



FOR STATE
HEALTH DEPT.



TO DEPUTY
Please execute
in case, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 9 & 21 Film 296
9-27-61 a.m.s
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6968

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66956

1. PLACE OF DEATH

a. COUNTY

Montgomery
(If outside corporate limits, write RURAL and give nearest town)

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN lb

MARYLAND

DOA

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington Sanitarium + Hosp

First
3. NAME OF
DECEASED
(Type or print)

Middle

David Reed La Roche

4. SEX

M

6. COLOR OR RACE

WU

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

10-21-58

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

13. FATHER'S NAME

Ronald P. La Roche

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

None

Ronald P. LaRoche-Father-same 2d

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

442X

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

Early Acute interstitial pneumonia

(b)

THINNING

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

14. MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING CAUSE OF DEATH.

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20d. INJURY OCCURRED While at work Not While at work

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

6/16/61

23. FUNERAL DIRECTOR

Robert A. Pumphrey

22c. NAME OF CEMETERY OR CREMATORI

Arlington Nat. Cem.

ADDRESS

22d. LOCATION (City, town, or country)

Arlington, Virginia

(State)

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

V.S. AISM
SM 9 60

DATE JUN 16 '61

Arthur S. Thane



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06957

6963

TO HOSPITAL OR CLINIC: The law requires that the death certificate be executed in 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please move carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u>		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>20 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM & HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BERTHA Elizabeth</u>		First <u>B</u>	Middle <u>E</u>
		Last <u>LAWSON</u>	
4. DATE OF DEATH <u>JUNE 25</u>		Month <u>JUNE</u>	Day <u>25</u>
		Year <u>1961</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
		8. DATE OF BIRTH <u>3-25-86</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) <u>Clarendon, Penn Amer.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Clarendon, Penn Amer.</u>	
13. FATHER'S NAME <u>Clarence Myers</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Jane Snyder</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? [Yes, no, or unknown] [If yes, give war or dates of service] <u>No.</u>		16. SOCIAL SECURITY NO. <u>D</u> INFORMANT <u>175-05944 Copied from chart</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u>	
DUE TO DUE TO DUE TO		<u>Myocardial infarction</u>	
		<u>Plaqueized arteries or clausis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>May 19 61</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
		<u>Wilkinsburg, Pen. PA.</u>	
21. I certify that I attended the deceased from _____ alive on _____, and that death occurred at _____, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>922 Euclid Dr Silver Spring Md</u>	
ACTUAL SIGNATURE <u>Abram W. D. Arist</u>		DATE SIGNED <u>6-25-61</u>	
PHYSICIAN'S NAME (Type) <u>Abram W. D. Arist</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-28-61</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>WOODLAWN</u>
		22d. LOCATION (City, town, or county) (State) <u>WILKINSBURG, PENNA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. Collins</u>		ADDRESS <u>3821-14th St. N.W. D.C.</u>	24a. REC'D BY REGISTRAR DATE JUN 28 '61
		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	



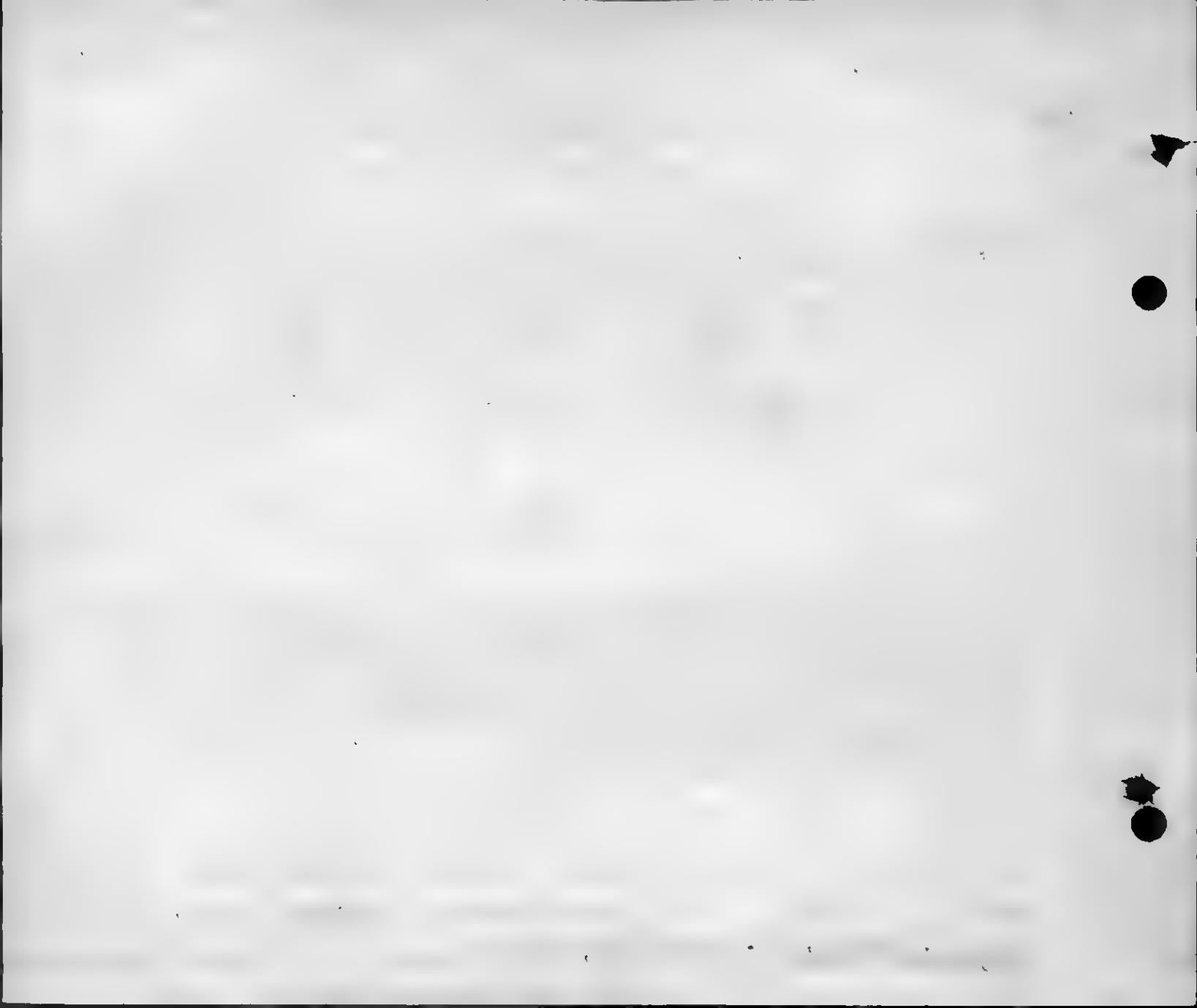
TO HOSPITAL **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Please retain by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
<i>Montgomery</i>		a. STATE	<i>Maryland</i> b. COUNTY <i>Montgomery</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
<i>Kensington</i>		<i>Seven years</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. STREET ADDRESS	
<i>Home, 3100 Jennings Rd.</i>		<i>3100 Jennings Rd.</i>	
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Antonio</i>		<i>NM</i>	<i>Lopes</i>
4. DATE OF DEATH		Month	Day
		<i>June</i>	<i>27</i>
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
<i>male</i>		<i>white</i>	<input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
8. DATE OF BIRTH		9. AGE (in years last birthday)	
		<i>April 1, 1880</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Merchant</i>		<i>Grocery</i>	
11. BIRTHPL. ACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Italy</i>		<i>Italy</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Salvatore Lopes</i>		<i>ANTINETTE Samperi's</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and dates of service)		16. SOCIAL SECURITY NO.	
<i>No</i>		<i>579-28-4261</i>	
17. INFORMANT		Address	
<i>Joseph Lopes</i>		<i>3100 Jennings Rd., Kensington</i>	
18. CAUSE OF DEATH [Enter on one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>1 day</i>	
<i>Uremia</i>		<i>6 months</i>	
DUE TO (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<i>Multiple Myeloma</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
		<i>Old Fracture, left hip</i>	
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Nov. 5, 1960</i> to <i>June 27, 1961</i> , that (I) (we) last saw the deceased alive on <i>June 24, 1961</i> , and that death occurred at <i>10 P.M.</i> from the causes and on the date stated above.		22b. DATE SIGNED <i>June 27, 1961</i>	
22a. SIGNATURE <i>John C.K. Yu</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>John C.K. Yu</i>		STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS <i>4912 Adrian St., Rockville, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7/1/61</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Gate of Heaven Cemetery</i>
23d. LOCATION (City, town or county) <i>Montgomery County, Maryland</i>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Pumphrey, Inc.</i>		25a. REC'D BY REGISTRAR <i>Date Jul 5 '61</i>	25b. REGISTRAR'S SIGNATURE <i>Carrie S. Kraus</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

M C I 61- 1		6971		88214	
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>Suburban Hospital</i>		d. STREET ADDRESS <i>Route #2 Box 205</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban Hospital</i>		4. DATE OF DEATH <i>June 3 1961</i>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>BABY Girl "A" LYLES</i>		5. SEX 6. COLOR OR RACE <i>Female colored</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>6-2-61</i>		9. AGE (in years) IF UNDER 1 YEAR last birthday <i>1 yr.</i>		10. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <i>Montgomery Co. Md.</i>	
10b. KIND OF BUSINESS OR INDUSTRY <i>10c. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Montgomery Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY <i>7 50</i>	
13. FATHER'S NAME <i>Alfred Done</i>		14. MOTHER'S Maiden Name <i>Catherine Mae Lyles.</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give rank or grade of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>17. INFORMANT</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>776X</i>		DUE TO <i>Prematurity</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.		DUE TO <i>(b)</i>			
DUE TO <i>(c)</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that <i>ME</i> (this hospital) attended the deceased from... <i>June 2 1961</i> , to <i>June 3 1961</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that death occurred at <i>4 PM</i> , from the causes and on the date stated above.				22b. DATE SIGNED	
22c. SIGNATURE <i>Mabel H. Grosvenor, M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <i>2203 Wyoming, N.W., Wash. D.C.</i>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <i>CREMATION</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>SUBURBAN HOSPITAL</i>		23d. LOCATION (City, town or county) <i>GEOGETOWN RD., BETHESDA, MARYLAND</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Amelia Carter - ADM. - SUBURBAN HOSPITAL BETHESDA, MD.</i>		ADDRESS <i>(per F.B.I.)</i>		25a. REC'D. BY REGISTRAR <i>JUL 13 1961</i>	
				25b. REGISTRAR'S SIGNATURE <i>Curry A. Miller</i>	
2174262 X VI		DATE			



TO HOSPITAL may be rebonded by physician or attending physician.
TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

6972

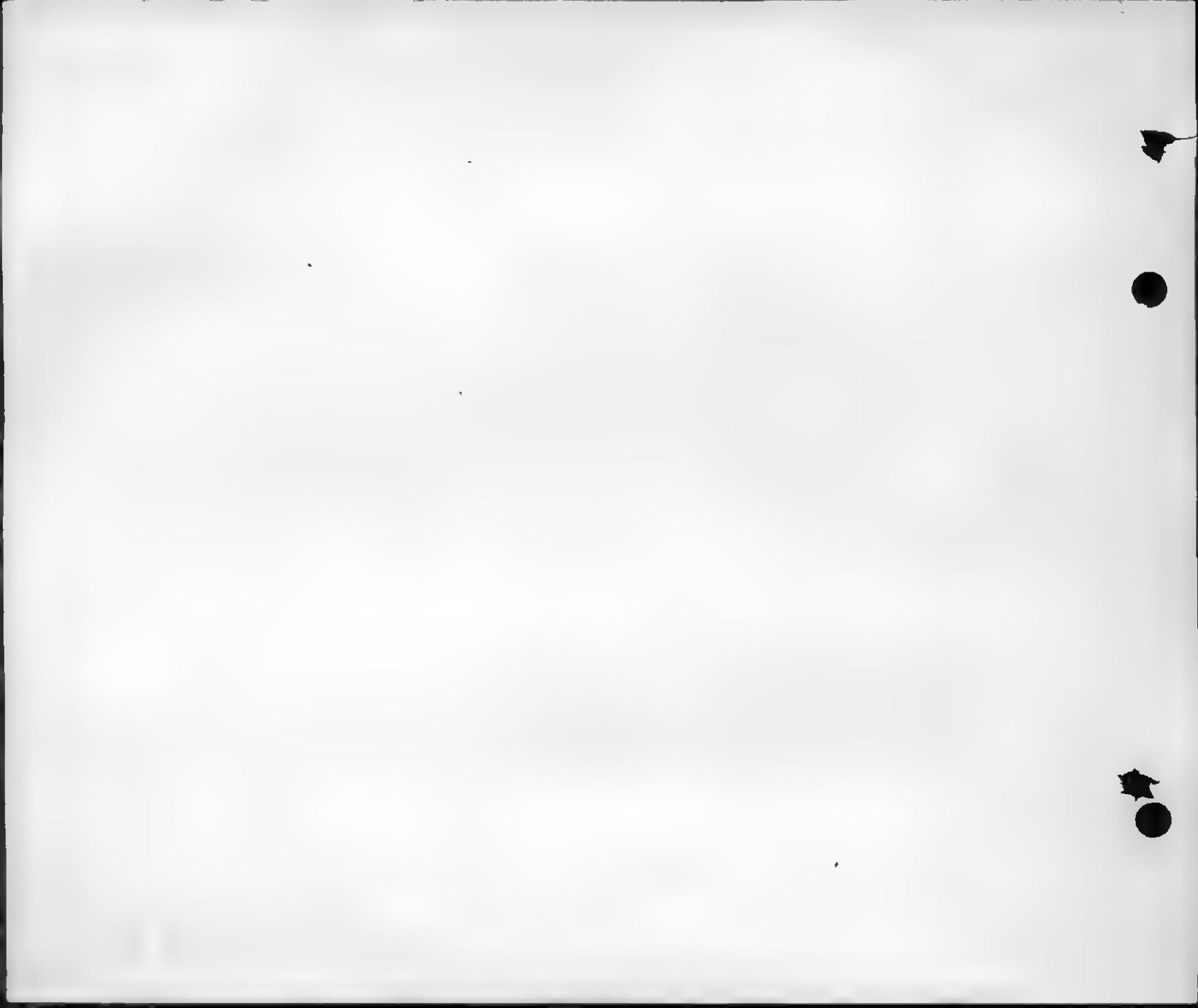
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02215

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>Suburban Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		d. STREET ADDRESS <i>Route #2 Box 205 1</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>				d. STREET ADDRESS <i>Route #2 Box 205 1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Baby Girl "B" Hayes</i>		First	Middle	Last	4. DATE OF DEATH <i>June 3 1961</i>	Month	Day	Year	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>C.</i>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <i>6-2-61</i>	7. AGE (In years lost birthday) — yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min	
10a. JSUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Alfred Dow</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Mae Hayes</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO		17. INFORMANT		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity</i>									
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Georgetown</i>		(County) <i>Washington</i> (State) <i>D.C.</i>	
21. I certify that <i>Amelia Carter - Adm.</i> attended the deceased from <i>June 2 1961</i> to <i>June 3 1961</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that death occurred at <i>4:30 AM</i> , from the causes and on the date stated above.									
22a. SIGNATURE <i>M. Grosvenor</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>July 13 1961</i>					
22c. PHYSICIAN'S NAME (Type) <i>M.H. GROSVENOR, M.D.</i>		22d. ADDRESS <i>2203 Wyoming, N.W., Wash., D.C.</i>							
23a. BURIAL, CREMATON, REMOVAL (Specify) <i>CREMATION</i>		23b. DATE THEREOF <i>7-4-61</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>SUBURBAN HOSPITAL</i>		23d. LOCATION (City, town, or county) <i>OLD GEORGETOWN ROAD, BETHESDA, MARYLAND</i>			(State)
24. FUNERAL DIRECTOR'S SIGNATURE <i>Amelia Carter - Adm. -</i>		ADDRESS <i>SUBURBAN HOSPITAL, BETHESDA, MD.</i>		25a. REC'D BY REGISTRAR <i>Amelia L. Green</i>		25b. REGISTRAR'S SIGNATURE <i>Amelia L. Green</i>			
				DATE <i>JUL 13 1961</i>					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6973

CERTIFICATE OF DEATH

Reg. Dist. No. 06959

1. PLACE OF DEATH o. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Lewisdale		c. LENGTH OF STAY IN lb life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Lewisdale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD # 1, Monrovia		d. STREET ADDRESS RFD # 1, Monrovia		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First Harry	Middle --	Last Lyles	4. DATE OF DEATH June 12 1961	Month	Day	Year
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5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12, 1895	9. AGE (In years last birthday) 65 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Lewisdale, Md.	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME Vatchel Lyles	14. MOTHER'S MAIDEN NAME Clarsia Zigler	Address
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. WW 1	INFORMANT Mrs Edna Lyles, Item 2
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinoma of prostate with generalized metastases DUE TO 177X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 years
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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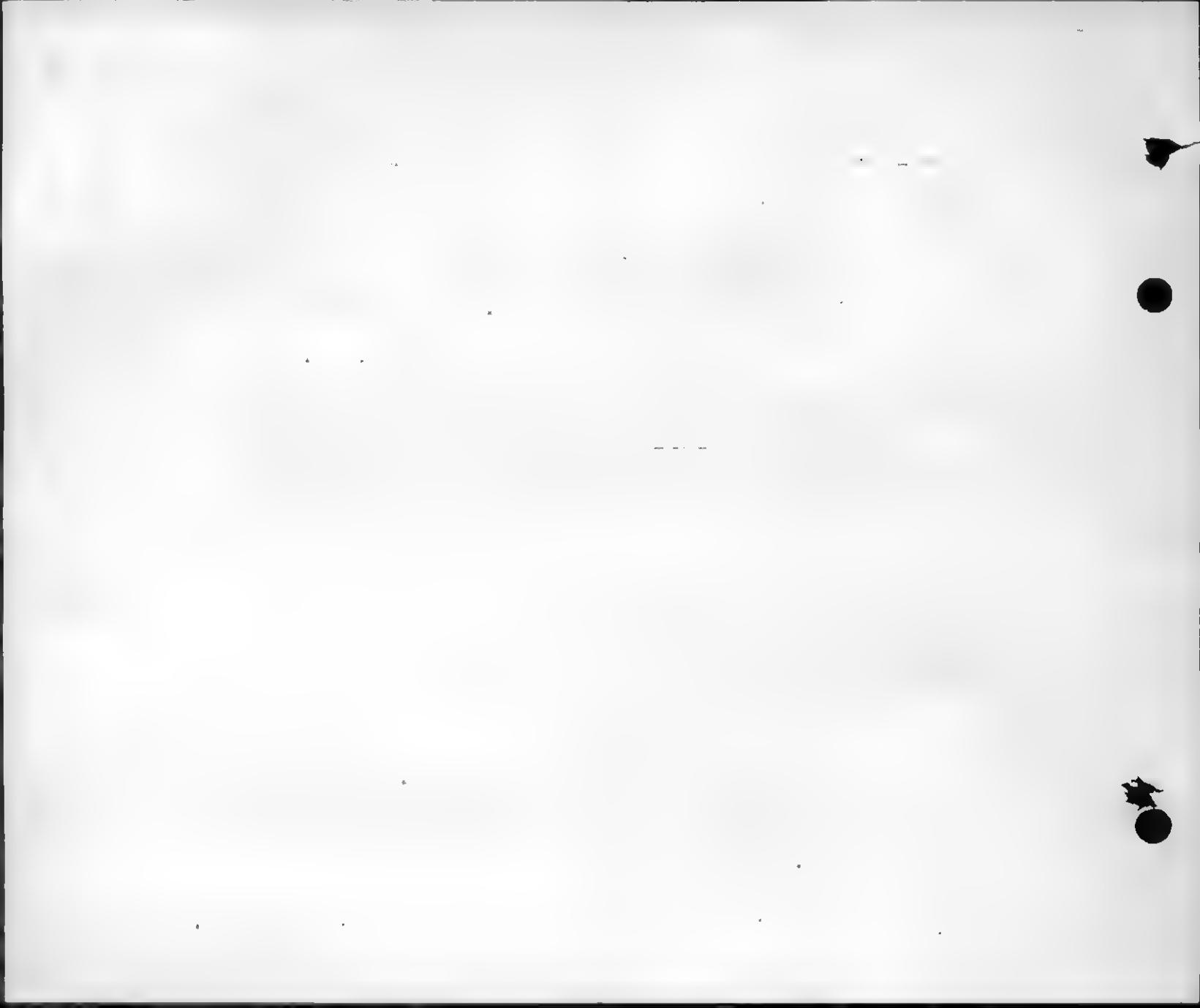
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/14 , 19 61 to 6/12 , 19 61 that I last saw the deceased alive on 6/11 , 19 61 , and that death occurred at 4A . M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Damascus, Md.	DATE SIGNED 6/12/61
--	--	---	-------------------------------

ACTUAL SIGNATURE James P. Kerr	PHYSICIAN'S NAME (Type) James P. Kerr
--	---

22a. BURIAL, CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF June 15, 1961	22c. NAME OF CEMETERY OR CREMATORIUM Pleasant Grove	22d. LOCATION (City, town, or county) Purdum, Md.	(State)
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23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Johnsmith	ADDRESS Damascus, Md.	24a. REC'D BY REGISTRAR DATE JUN 14 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Kress
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6974

CERTIFICATE OF DEATH

Reg. Dist. No.

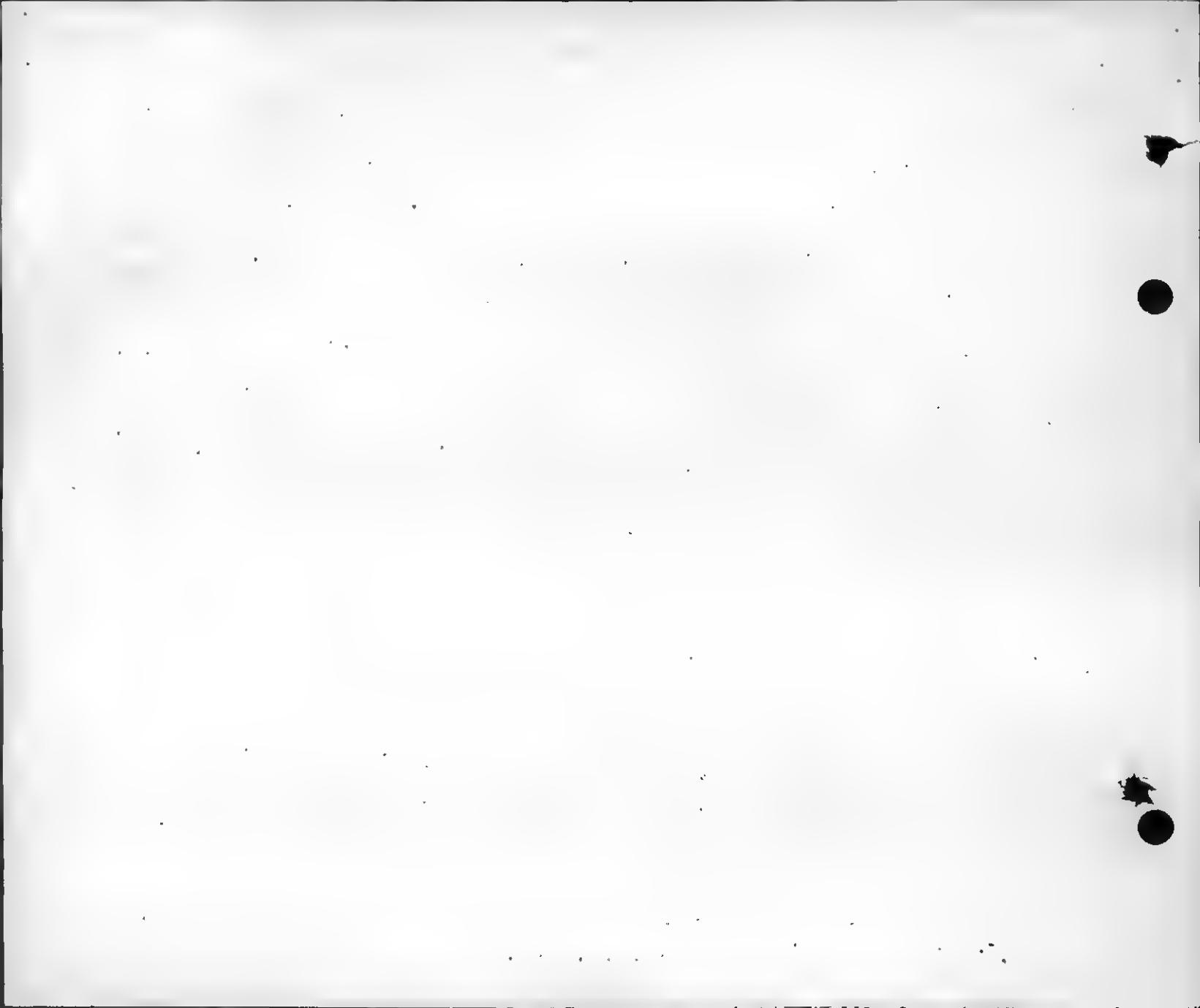
66960

HOSPITAL ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE					
Montgomery				Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		b. COUNTY					
RURAL and give nearest town)				Montgomery					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Suburban Hospital		3506 Raymond Street		Chevy Chase 52					
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
Christine		A.	Lynch		June 11				
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years lost birthday) yrs	IF UNDER 1 YEAR	IF UNDER 24 HRS		
Female		White		11-19-07	55 yrs	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife				Ohio		U.S.A.			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
John J. Lynch					Christina Campbell				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					INFORMANT				
No					Address				
16. SOCIAL SECURITY NO.					3506 S. S. Lincoln				
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					INTERVAL BETWEEN ONSET AND DEATH Today				
58yo DUE TO Hepatic Cancer Cushing's syndrome									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO } (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
19									
21. I certify that I attended the deceased from 6-3, 1961, to 6-11, 1961, that I last saw the deceased alive on 6-11, 1961, and that death occurred at 10 P.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Jay A. Bailey</i>					ADDRESS (Street, city or town, state) Wards 1st Clinic, Ward 6-12				
PHYSICIAN'S NAME (Type)					DATE SIGNED				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL			22d. LOCATION (City, town, or county)		(State)
Burial		6-14-61		Clifton Cemetery			Washington, D. C.		
22e. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		22f. REC'D BY REGISTRAR			22g. REGISTRAR'S SIGNATURE		
<i>Jane G. Collins</i>		1-14-61 St... on 11-30					<i>C. L. & Sons</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06961

PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda (Rural)

MARYLAND

c. LENGTH OF STAY IN 18

1 day

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

U. S. Naval Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Joseph

Bertram

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

Male

Caucasian

WIDOWED DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Officer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State or foreign country)

U. S. Navy

Massachusetts

13. FATHER'S NAME

Edward LYNCH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

Yes

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Hospital Records

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Hemorrhage, right cerebral hemisphere

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last

DUE TO

(b) Atherosclerosis, generalized

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (his hospital) attended the deceased from June 26, 1961, to June 27, 1961, that (we) last saw the deceased alive on June 27, 1961, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE

G. I. Walker Jr.

M.D.

ATTENDING
PHYS.MED
DIRECTORSTAFF
PHYS. 22b. DATE
SIGNED
6-28-6122c. PHYSICIAN'S
NAME (Type)

G. I. WALKER, JR. CAPT, MC, USN U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

6-30-61

23b. DATE THEREOF

Arlington National

23d. LOCATION (City, town or county)

(State)

Arlington

Virginia

24. FUNERAL DIRECTOR'S SIGNATURE

Jos. Gawlers & Sons, 1756 Penna. Ave., NW, Wash DC

25a. REC'D BY REGISTRAR

DATE JUN 30 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraft

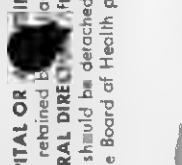


1

**TO HOSPITAL OR
HOSPITAL OR
TO FUNERAL DIRECTOR**
may be retained by the hospital or attending physician.
After this certificate has been signed by the attending physician and completed,
Page 3 should be detached for use as the burial-transit permit. Then please move carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, or in any event within 72 hours after death.

Page 4
is after
the funeral director.

050

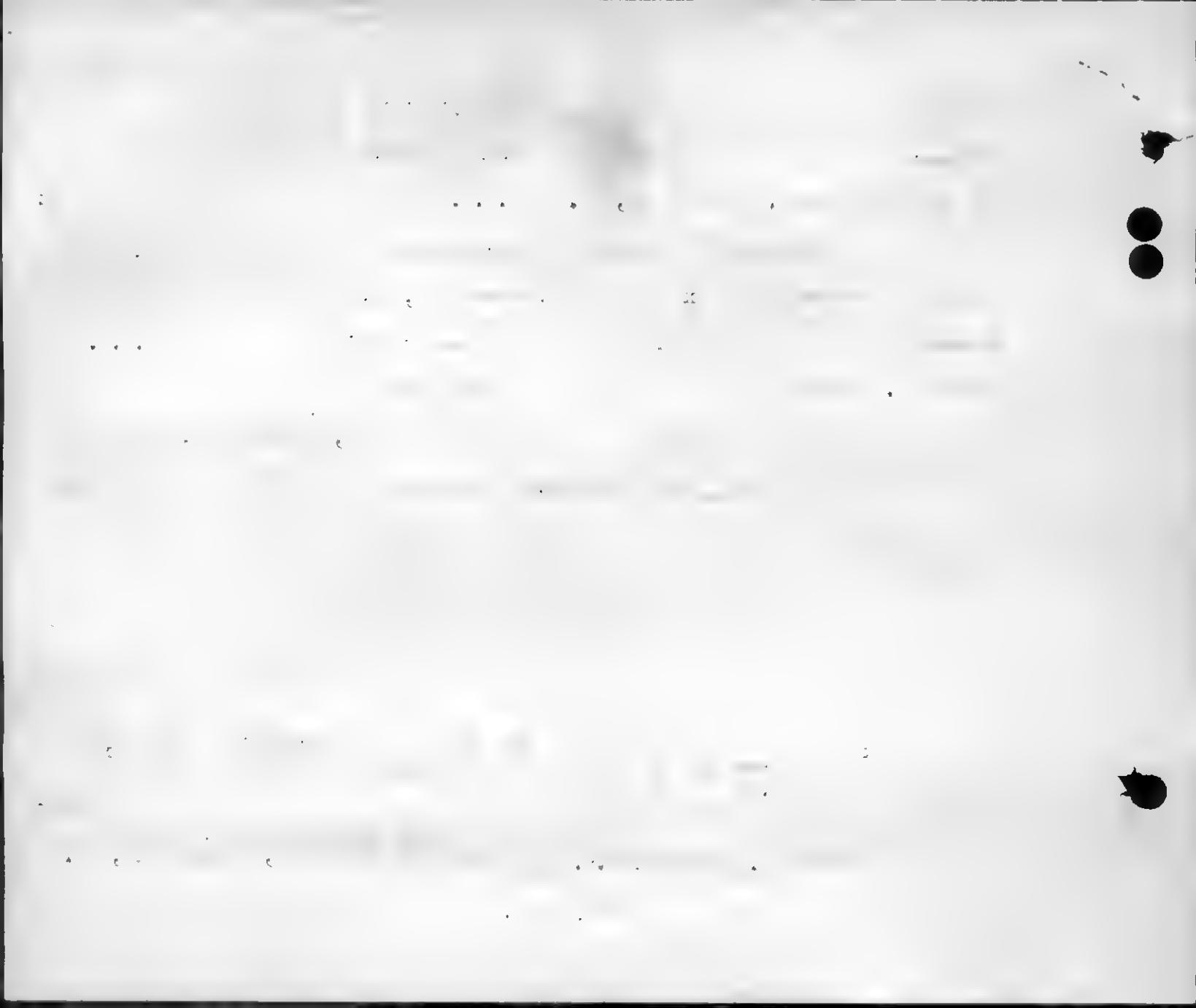


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06962

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE West Virginia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 19 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kearneysville		d. STREET ADDRESS R.F.D. # 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Caroline	Middle Thelma	Last Maccoughtry	4. DATE	Month June	Day 11	Year 1961
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH September 5, 1908	9. AGE (In years last birthday) yrs. 52	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William J. Heaton		14. MOTHER'S MAIDEN NAME Amelia Tagg					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Breast						INTERVAL BETWEEN ONSET AND DEATH 2 years	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 17		DUE TO (b) Metastatic Carcinoma of Breast					
DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 20 (this hospital) attended the deceased from May 23, 1961 to June 11, 1961 , that we last saw the deceased alive on June 11, 1961 , and that death occurred at 4:10 PM . Name the causes and on the date stated above.							
22a. SIGNATURE Benjamin A. Borowsky		22b. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE 6/12/61			
22c. PHYSICIAN'S NAME (Type) BENJAMIN A. BOROWSKY, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.					
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial-Trans		23b. DATE THEREOF 6/12/61		23c. NAME OF CEMETERY OR CREMATORIAL Episcopal Cemetery		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE JUN 13 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



1

TO HOSPITAL OR HOSPITAL DIRECTOR: The law requires that the death certificate be executed within 48 hours after death.

TO ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

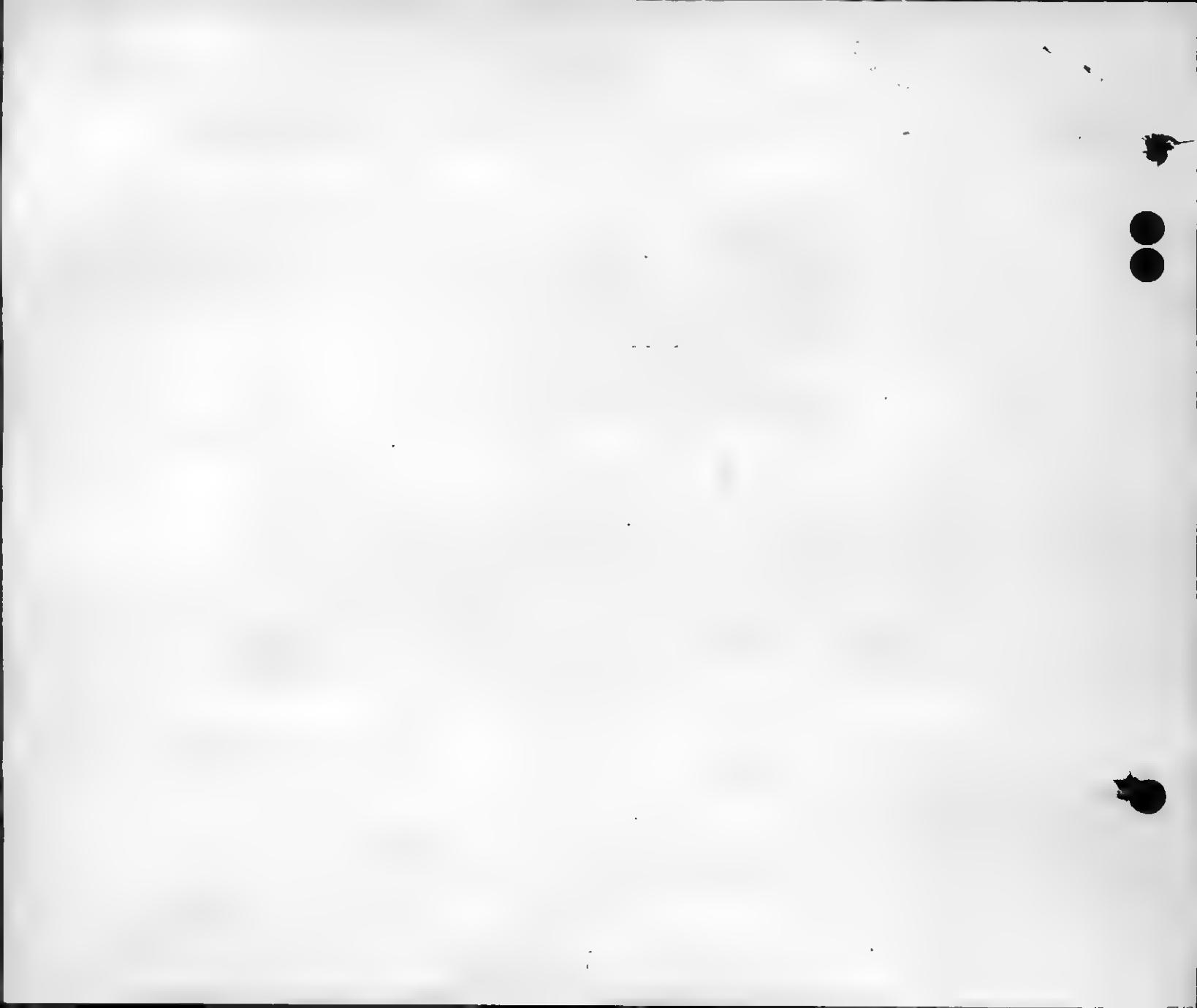
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6977

06963

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Potomac		d. STREET ADDRESS 10701 MacArthur Boulevard			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Nettie		First M.	Middle M.	Last Marsden	4. DATE OF DEATH June 28 1961	Month June	Day 28	Year 1961	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/19/1886		9. AGE (In years last birthday) 74 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME J. Theodore Hill			14. MOTHER'S MAIDEN NAME Emsey Henderson						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT (S) Robert B. Marsden, Chevy Chase, Md.		Address 4820 Chevy Chase Drive			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 432 <i>Cerebral Cardiovascular Disease</i> INTERVAL BETWEEN ONSET AND DEATH 5 years									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Malnutrition		DUE TO (b)		<i>Arteriosclerosis</i>					
		DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Malnutrition									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) July 1961 to June 28, 1961, that (I) was lost							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 2029 Bee St., nw, Wash. D.C.		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 1961 to June 28, 1961 , that (I) was lost saw the deceased alive on 27 June 1961 , and that death occurred at 2029 Bee St., nw, Wash. D.C. M, from the causes and on the date stated above.									
22a. SIGNATURE W. F. Cresswell, Jr.		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/28/61					
22c. PHYSICIAN'S NAME (Type) W. F. Cresswell, Jr.		22d. ADDRESS 2029 Bee St., nw, Wash. D.C.							
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/1/61		23c. NAME OF CEMETERY OR CREMATORIUM Potomac Church Cem.		23d. LOCATION (City, town, or county) Potomac, Maryland			(State)
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE JUL 6 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6978

CERTIFICATE OF DEATH

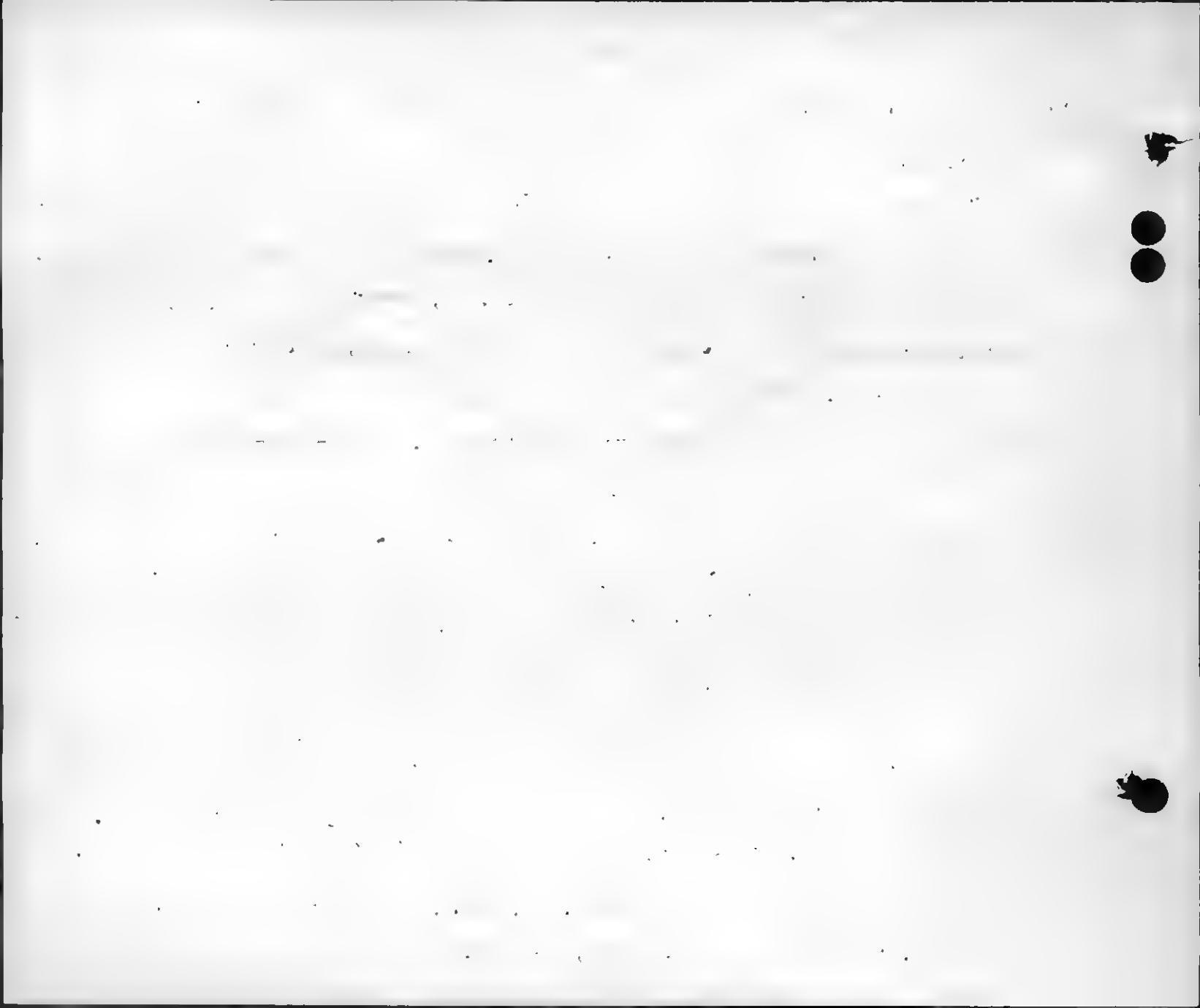
Reg. Dist. No.

06964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 838 Rockville Pike				d. STREET ADDRESS 838 Rockville Pike		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Wilbert		First Wilbert	Middle A	Last MARTH	4. DATE OF DEATH June 8 1961	Month June	Day 8	Year 19 61
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 25, 1909	9. AGE (In years last birthday) 52 yrs	IF UNDER 1 YEAR Months 3	IF UNDER 24 HRS Days 13	Hours Min.
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Radio repairman		10b. KIND OF BUSINESS OR INDUSTRY Radio		11. BIRTHPLACE (State or foreign country) Germantown, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William G. Marth				14. MOTHER'S MAIDEN NAME Ada Carter				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Unknown-yes		INFORMANT Gertrude M. Marth-wife-same Item #2		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure INTERVAL BETWEEN ONSET AND DEATH 3 days								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 44-3 X DUE TO (b) cardiovascular hypertension disease 3 years								
(c) cirrhosis of liver, with jaundice & ascites - 1 year.								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus - 5 years								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from July 8, 1960 to June 8, 1961 , that I last saw the deceased alive on July 7, 1961 , and that death occurred at 4:45 P.M. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) 110 S. Washington St., Rockville, Md.								
DATE SIGNED June 8, 1961								
ACTUAL SIGNATURE W. G. Marth		M.D.		W. A. Linthicum				
PHYSICIAN'S NAME (Type) W. A. Linthicum								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/10/1961		22c. NAME OF CEMETERY OR CREMATORIAL Rockville Cem. Assn.		22d. LOCATION (City, town, or county) Rockville		(State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE 9 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6979

06965

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Suburban Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Norma

L.

MASON

5. SEX

6. COLOR OR RACE

Female

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED DIVORCED

May 9, 1915

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Secretary

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (Country & State, or foreign country)

U. S. Government | Minnesota

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

None

Mrs. W. A. Sterba-Friend Address 8800 Bradmoor Drive Bethesda, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO

(c)

Carcinomatosis (Breast)

INTERVAL BETWEEN
ONSET AND DEATH
24 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(b)

Peripheral Circulatory Failure

1 Mo.

6 yrs.

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED
p.m. While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (his hospital) attended the deceased from

1957, 19 to 6-10, 1961, that (I) (we) last

saw the deceased alive on 6-9 1961, and that death occurred at 3:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE

James W. Long, M.D.

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED
6-10-6123a. BURIAL, CREMATION
REMOVAL (Specify)
Bur-transit | 6-10-61

23b. DATE THEREOF

Hebbing Park Cemetery

23d. LOCATION (City, town or county)

(State)

St. Louis County, Minn.

24 FUNERAL DIRECTOR'S SIGNATURE

Robert A. Pumphrey

ADDRESS

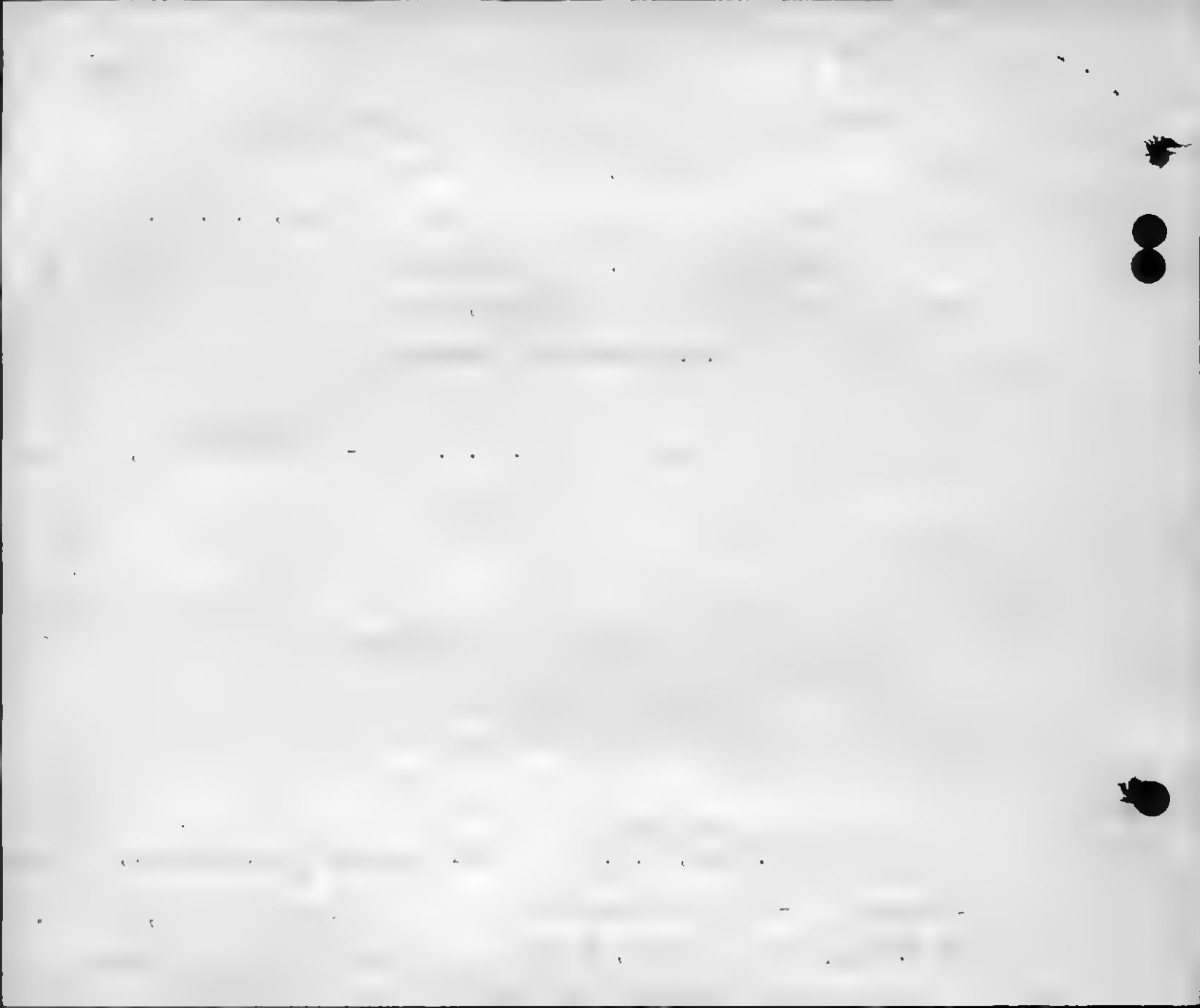
Bethesda, Maryland

25a. REC'D BY REGISTRAR

DATE JUN 13 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Trahan



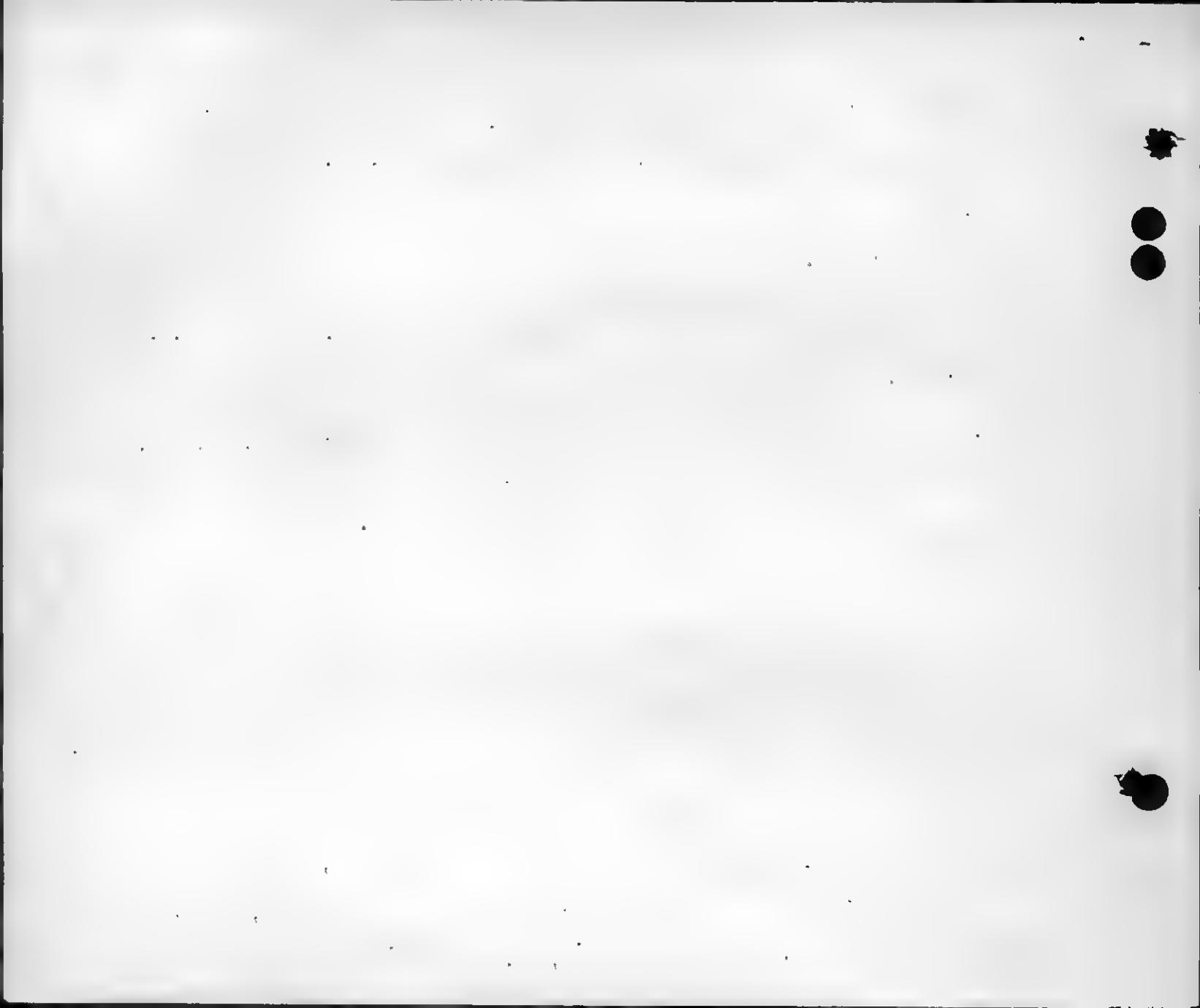
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6980

06966

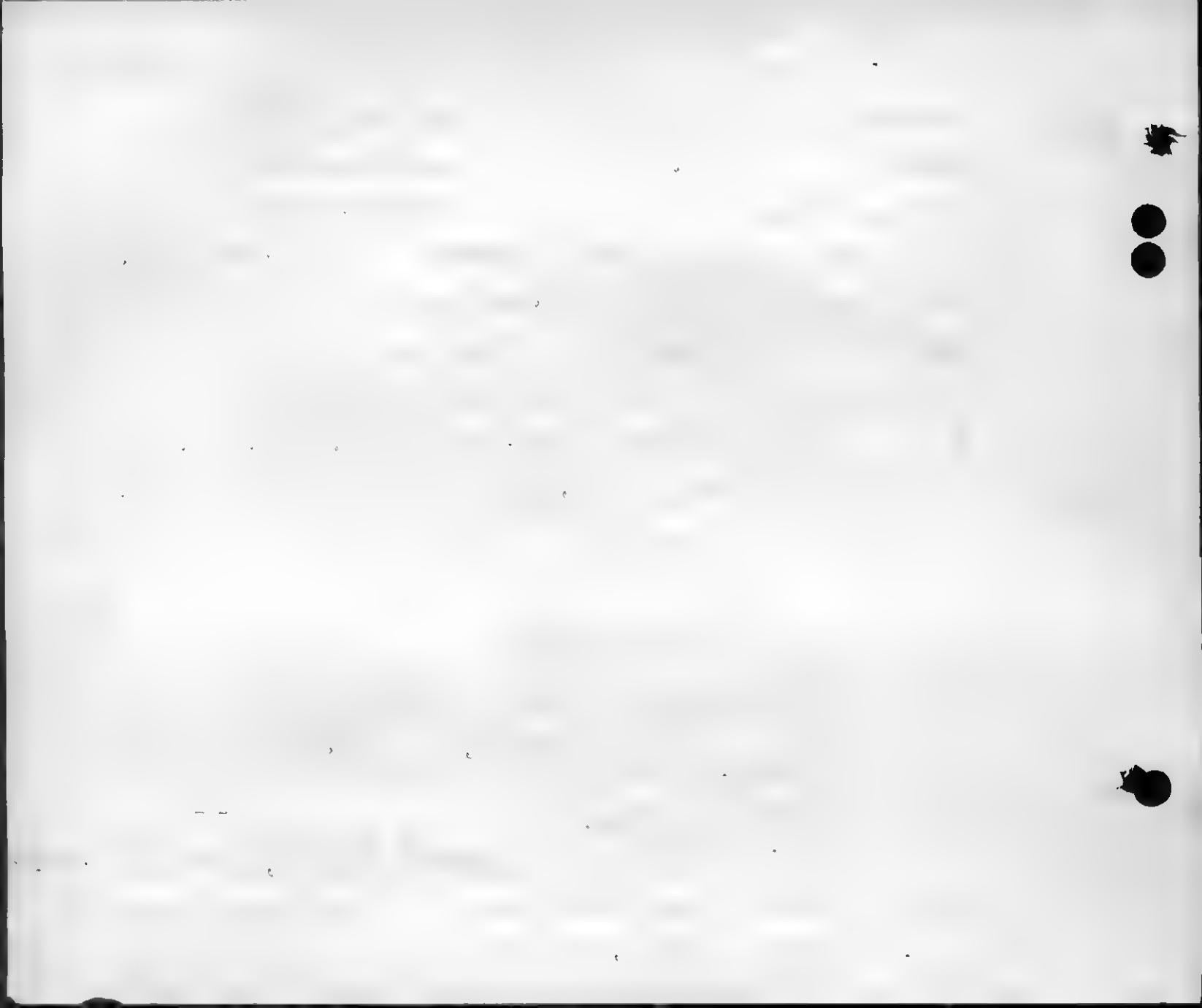
TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Md.		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda.		c. LENGTH OF STAY IN 1b 19 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg, Rt. 3 Maryland X				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Grace M. McCrossin		First	Middle	Last	4. DATE OF DEATH June 17 1961	Month	Day	Year
5. SEX female		6. COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/12/78	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hwf		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Darnestown, Md.		12 CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Edward S. Hunter				14. MOTHER'S MAIDEN NAME Anna Virginia Hunter				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Bertha Myers Gaithersburg, Rt. 3 Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA INTERVAL BETWEEN ONSET AND DEATH 3 wk								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. (b) ARTERIOSCLEROTIC HEART DISEASE 2 yr.								
DUE TO (c) CERFERAL THROMBOSIS WITH HEMIPLEGIA 2 wk.								
DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from JUNE 17 1961, and that death occurred at 3:30 PM, from the causes and on the date stated above								
22a. SIGNATURE <i>Leo M. Curtis</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) Leo M. Curtis		22d. ADDRESS 8218 Wisconsin Avenue Bethesda, Maryland						
23a. BURIAL, CREMAT. ON REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 6/ 20/ 61	23c. NAME OF CEMETERY OR CREMATORIUM Rockville Cemetery		23d. LOCATION (City, town, or county) Rockville, Maryland			(State)
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home		ADDRESS 1331 F. Montgomery Ave Rockville, Md.		25a. REC'D BY REGISTRAR DATE JUN 20 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death, or if the deceased has been retained by a physician or attending physician, within 72 hours after this certificate has been signed by the attending physician or physician or attending physician. After this certificate has been signed by the attending physician or physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH								
1. PLACE OF DEATH a. COUNTY Montgomery				MARYLAND				2. USUAL RESIDENCE (Where deceased lived — If institution, Residence before admission)												
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 24 days				d. STATE New York				b. COUNTY								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center								c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Long Island, Freeport												
3. NAME OF DECEASED (Type or print) Cora				First	Middle	Last	4. DATE OF DEATH McDermott		Month	Day	Year	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH January 12, 1915		9. AGE (In years last birthday) 46 yrs		10. IF UNDER 1 YEAR Months 4 Days 16 Hours 0 Min. 0			11. IF UNDER 24 HRS								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (State or foreign country) New York				12. CITIZEN OF WHAT COUNTRY? USA								
13. FATHER'S NAME Albert Haeffer				14. MOTHER'S MAIDEN NAME Josephine Englehart																
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland												
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Aortic stenosis, mitral stenosis												3 years								
DUE TO Rheumatic fever												35 years								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Pulmonary atelectasis																				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary atelectasis												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from May 15, 1961 to June 8, 1961 that (I) (we) last saw the deceased alive on June 8, 1961 , and that death occurred at 2:25 PM from the causes and on the date stated above																				
22a. SIGNATURE <i>Robert J. Levine, M.D.</i>												22b. DATE SIGNED 6-8-61								
22c. PHYSICIAN'S NAME (Type) Robert J. Levine			M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>														
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit												23b. DATE THEREOF 6/9/1961			23c. NAME OF CEMETERY OR CREMATORIAL Lutheran Cemetery			23d. LOCATION (City, town, or county) Middle Village New York		
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey												ADDRESS Bethesda, Maryland			25a. REC'D BY REGISTRAR DAT 12 12 '61			25b. REGISTRAR'S SIGNATURE Clinton S. Krause		



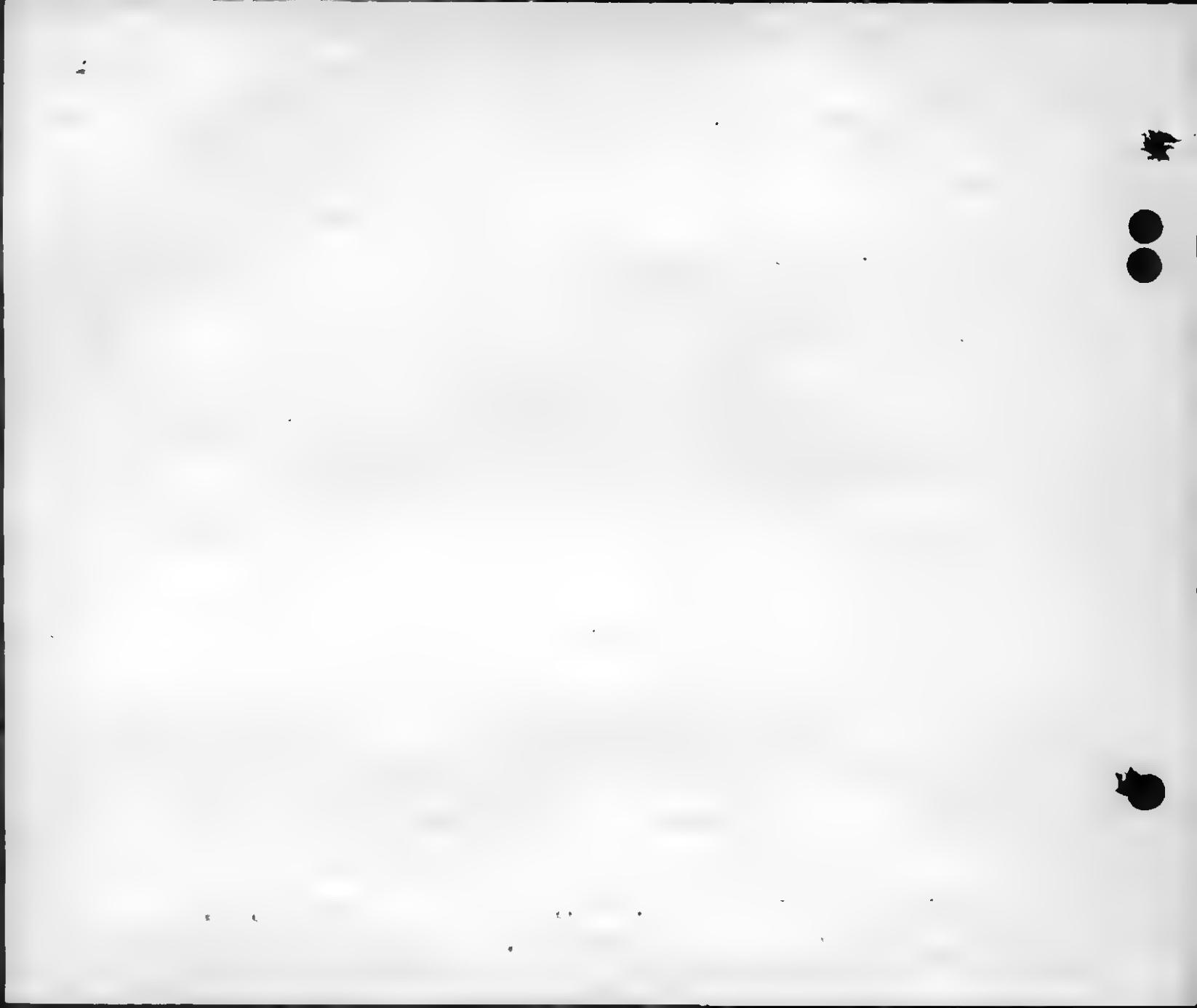
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death may be removed from the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. STATE M.D.	
RD3 Gaithersburg				b. COUNTY Montgomery	
b. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
				X RD3, Gaithersburg	
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month Day Year
George				McDonald	6 5 1961
5. SEX	6. COLOR OF RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (in years last birthday) yrs	IF UNDER 1 YEAR Months Days Hours Min.
Male	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Feb. 11 1886	75 3	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Henry McDonald		Lucy Mason		U.S.A	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
(If yes, give war or dates of service)				Helen McDonald, Wife, RD3 Gaithersburg	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)					
420.1 DUE TO Coronary Artery Occlusion, 1 HR.					
Conditions, if any, which gave rise to immediate cause (a), stating the under- (b)					
cause (b), stating the under- (c)					
ly ing cause lost.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
Varicose ulcers Lt. Lower leg.					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from 7-6 1960 to 6-5 1961, that (I) (we) last saw the deceased alive on 7-6 1960, and that death occurred at 9:50 A.M. from the causes and on the date stated above					
22a. SIGNATURE		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED G-9-61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		202 Martin L. King, Rockville Md.	
23a. BLR AL. CREMATION REMOVAL (Specify)		23b. DATE THEREOF 6/8/61		23c. NAME OF CEMETERY OR CREMATORIAL St. Paul.,	
Burial				23d. LOCATION (City, town, or county) (State)	
				Sugarland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR DATE JUN 20 '61	
Robert L. Snowden				25b. REGISTRAR'S SIGNATURE	
				Carroll S. Evans	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death.

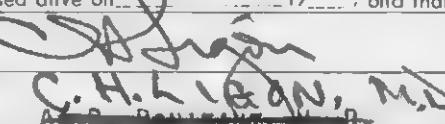
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

6983

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06969

1. PLACE OF DEATH a. COUNTY MONTGOMERY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY			c. LENGTH OF STAY IN lb 8 DAYS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) MARY			First	Middle	Last
4. DATE OF DEATH JUNE 7 1961			Month	Day	Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	b. DATE OF BIRTH 6/19/1882	9. AGE (In years last birthday) 78 yrs	10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS Months Days Hours Min
10a. JSL AL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME			10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) MARYLAND, BALTIMORE	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME ROBERT FREE			14. MOTHER'S MAIDEN NAME SUSAN BARNES		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —			16. SOCIAL SECURITY NO. —	17. INFORMANT HOSPITAL RECORDS, OLNEY, MD.	Address —
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) INFARCTION OF BRAIN (LEFT PARIETAL Lobe) 8 days DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause ast. (b) THROMBOSIS BASILAR ARTERY 8 days DUE TO (c) GENERALIZED MATERIOSCLEROSIS YES					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)	20f. (City or town) —	(County) (State) —
21. I certify that (I) (this hospital) attended the deceased from 5/31 7:41 to 6/2 1961 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at AM , from the causes and on the date stated above.					
22a. SIGNATURE 			M D	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 6/7/61
22c. PHYSICIAN'S NAME (Type) C. H. L. BRYAN, M.D.			22d. ADDRESS SANDY SPRING, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 10, 1961	23c. NAME OF CEMETERY OR CREMATORIAL Kock Creek Cemetery	23d. LOCATION (City, town, or county) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters			ADDRESS 254 Carroll St. New Haven	25e. REC'D BY REGISTRAR C. Arthur Walters	25f. REGISTRAR'S SIGNATURE Arthur S. Thrua
				DATE JUN 9 '61	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

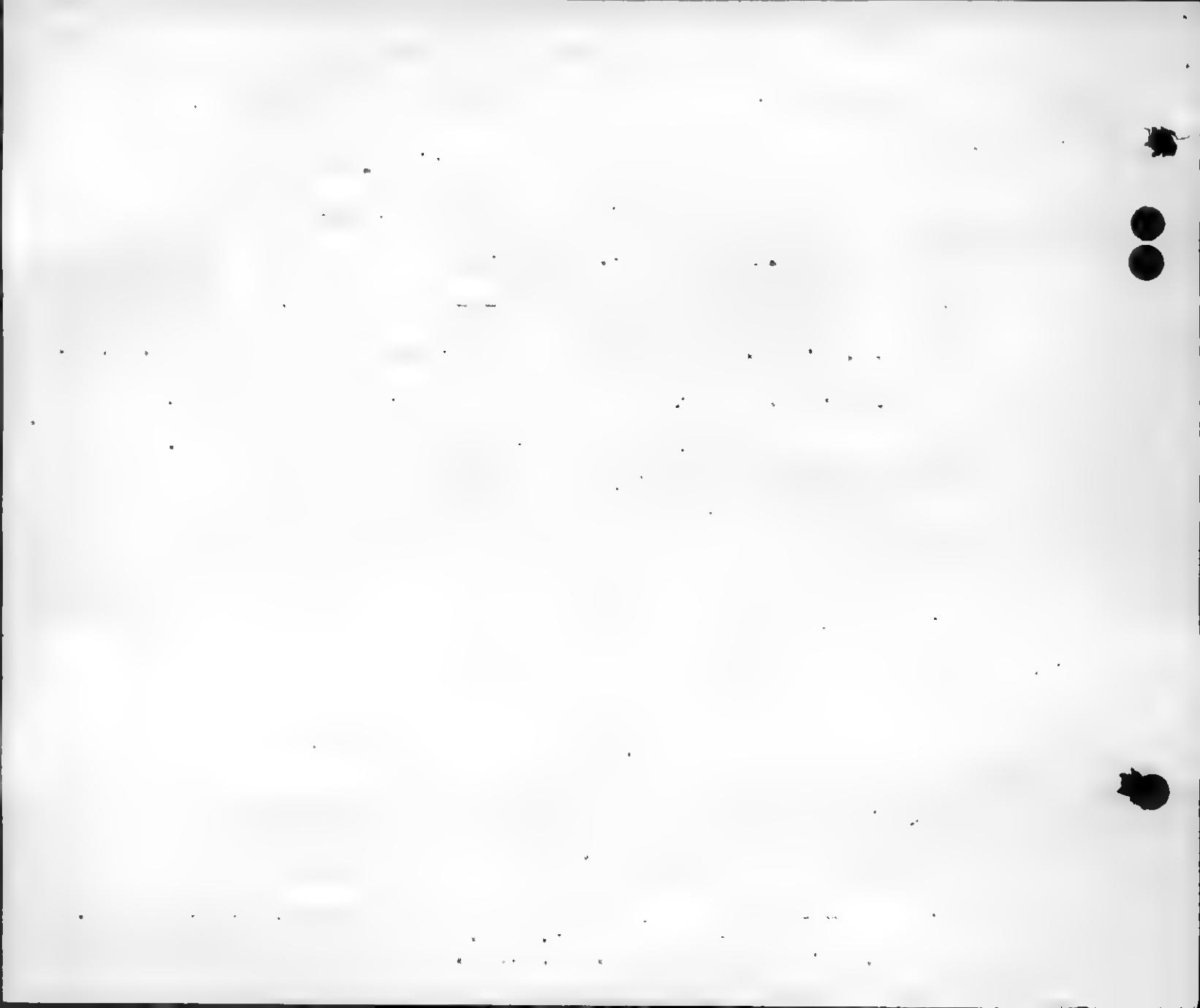
CERTIFICATE OF DEATH

Reg. Dist. No.

06970

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death by a hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park Md		2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
c. LENGTH OF STAY IN lb 9 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7300 Baltimore Avenue		d. STREET ADDRESS 1901 Ingraham Street	
3. NAME OF DECEASED First JAMES Middle P. MCKEON		4. DATE OF DEATH Month 6 Day 2 Year 1961	
5. SEX Male COLOR OR RACE White MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6. DATE OF BIRTH 3-4-78 9. AGE (In years lost birthday) 83 yrs IF UNDER 1 YEAR Months Days Hours Min	
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired U.S. Gov't.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME MICHAEL J. MCKEON		14. MOTHER'S MAIDEN NAME MARGARET W. CRIPPS Address Mass.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Informant Henrietta Dumas #8 Upland Rd. Everett,	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio - Sclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		DUE TO Arterio - Renal Failure DUE TO _____ DUE TO _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Arterio - Sclerotic Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/18/56 , 19, to 6/2/61 , 19, alive and that death occurred at 8:55 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 4501 - Concourse Ave. New. York DATE SIGNED	
ACTUAL SIGNATURE James G. O'Keefe		M.D.	
PHYSICIAN'S NAME (Type) James G. O'Keefe MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-6-61	
22c. NAME OF CEMETERY OR CREMATORIAL Holy Cross Cemetery		22d. LOCATION (City, town, or county) (State) Malden, MASS.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Collins		ADDRESS WASH. D. C.	
FRANCIS J. COLLINS 3821 14th. St. N. W.		24a. REC'D BY REGISTRAR JUN 6 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

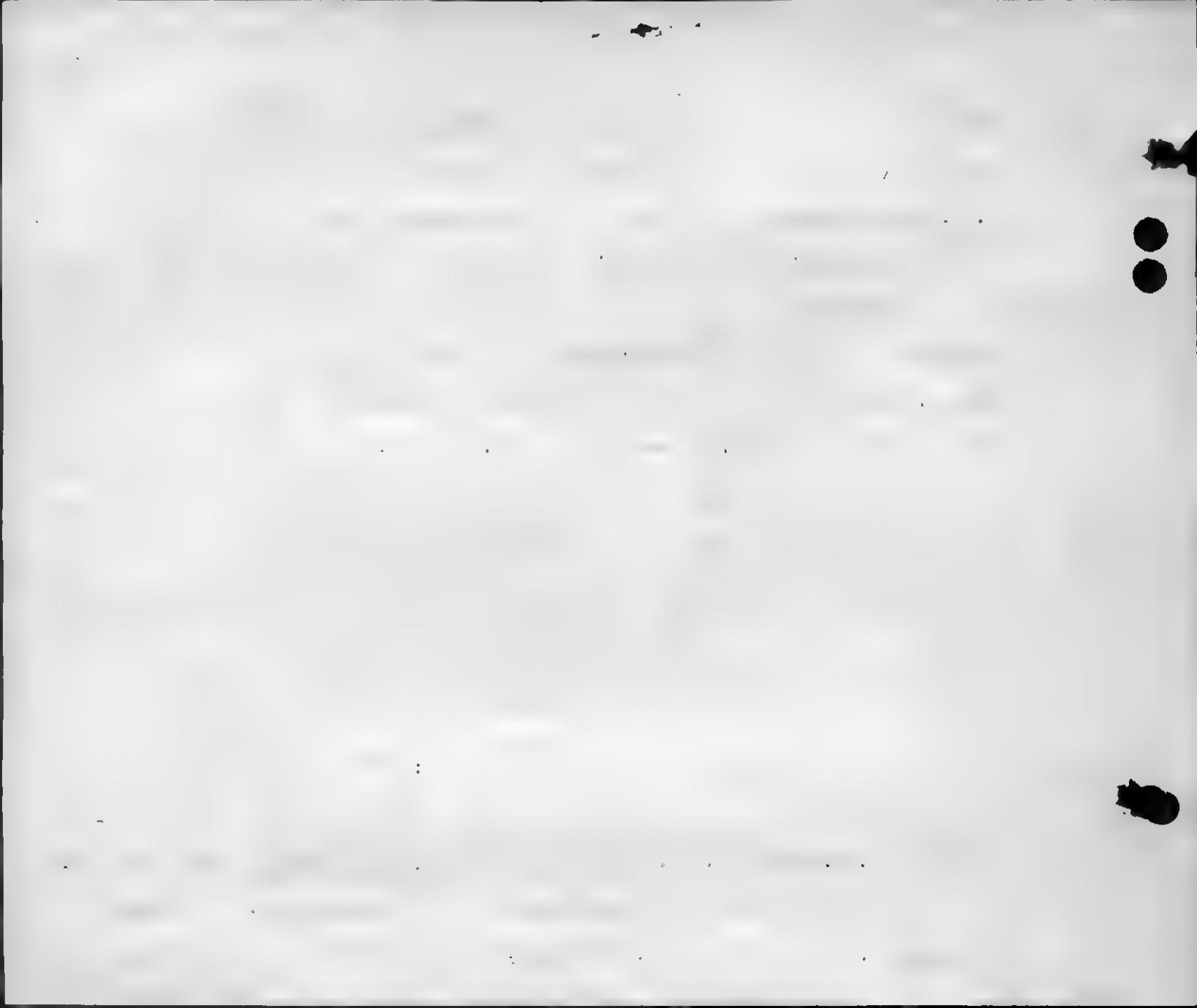
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6985

06971

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		b. COUNTY Wicomico	
c. LENGTH OF STAY IN 1b 35 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 113 Clyde Avenue	
3. NAME OF DECEASED (Type or print) James		4. DATE OF DEATH Month Day Year MEARS June 12 1961	
5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 3-5-30	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years) IF UNDER 1 YEAR last birthday Months Days Hours Mins 31 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repairman		10b. KIND OF BUSINESS OR INDUSTRY Office Machines	
11. BIRTHPLACE County & State, or foreign country Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James W. MEARS		14. MOTHER'S MAIDEN NAME Mary E. CHANCE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or date of service Yes 1/5/51 to 3/52		16. SOCIAL SECURITY NO 17. INFORMANT 220-26-4129 (W) Mrs. Edoth C. Mears, same as #2 above	
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>aortic insufficiency</i>		INTERVAL BETWEEN ONSET AND DEATH <i>20 yrs</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>rheumatic heart disease</i>			
DUE TO (c)			
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 8 1961 to June 12 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 12 1961 , and that death occurred at 6:25 AM from the causes and on the date stated above.			
22e. SIGNATURE <i>B. H. Rice</i>		22b. DATE SIGNED 6-12-61	
22c. PHYSICIAN'S NAME (Type) B. H. RICE, LT, MC, USN		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23e. BURIAL, CREMATION, REMOVAL (Specify) Burial		23c. NAME OF CEMETERY OR CREMATORIUM Wicomico Cemetery	
23d. LOCATION (City, town or county) Wicomico Co. Maryland		23e. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Arthur S. Thorne	
24. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co., 414 E. Church St., Salisbury, Md.		ADDRESS DATE JUN 16 '61	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

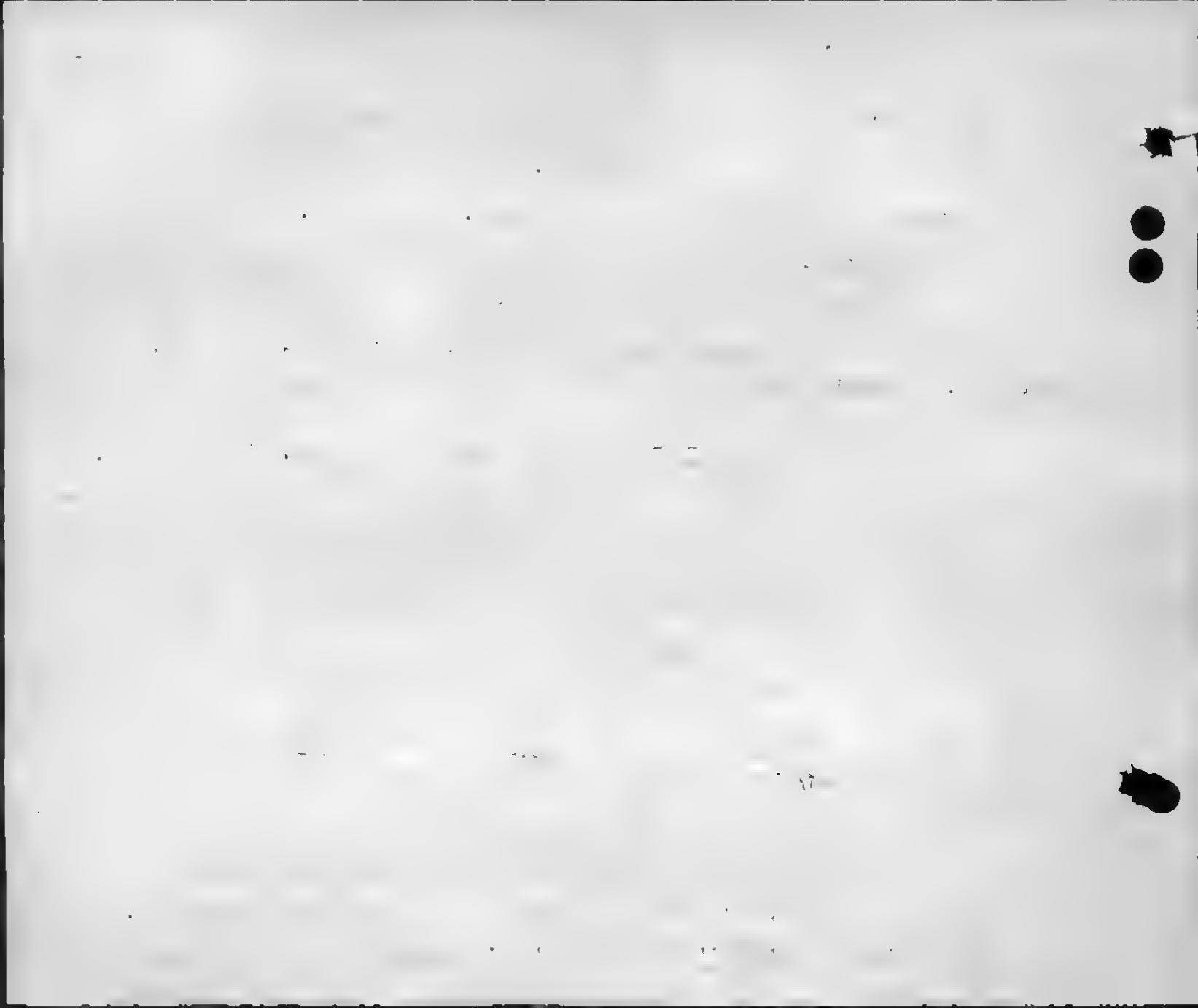
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4 may be filed with the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06972

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE New Jersey b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 22 hours 15 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Atlantic City							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban		d. STREET ADDRESS 64 S. Carolina Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Mary E. Mehan		First Middle Last		4. DATE OF DEATH June 17 Month Day Year 1961							
5. SEX female white		6. COLOR OR RACE WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 3/23/86							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W. Fur finisher (retired)		10b. KIND OF BUSINESS OR INDUSTRY Furrier		11. BIRTHPLACE (County & State, or foreign country) Bird In Hand, Penn.							
13. FATHER'S NAME John R. Frank Wilson		14. MOTHER'S MAIDEN NAME Unknown ? Knightie		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no unknown) (If yes give rank or date of service) no							
16. SOCIAL SECURITY NO. 150-09-3394		17. INFORMANT Mary Auel 41 Maytide St. Pittsburgh, Pa.		Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4+ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)		Cerebral vascular accident Hypertensive cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH 36 hours without years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) June 16, 1961		20f. (City or town) (County) (State) June, 1961 (Rockville) MD.	
21. I certify that (I) (this being my) attended the deceased from <u>June 16, 1961</u> to <u>July 17, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 17, 1961</u> , and that death occurred at <u>6 p.m.</u> from the causes and on the date stated above.											
22a. SIGNATURE G. Bowditch Hunter, Jr.		22b. DATE SIGNED 6/17/61		M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) G. Bowditch Hunter, Jr., M.D.		22d. ADDRESS 809 Veirs Mill Rd. Rockville MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 21, 1961		23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery		23d. LOCATION (City, town or county) Montgomery County, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE R. E. Pimphrey, Inc., Silver Spring, Md.		ADDRESS Raymond A. Ziska		25a. REC'D BY REGISTRAR DATE JUN 26 '61		25b. REGISTRAR'S SIGNATURE Charles S. Kraus					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06973

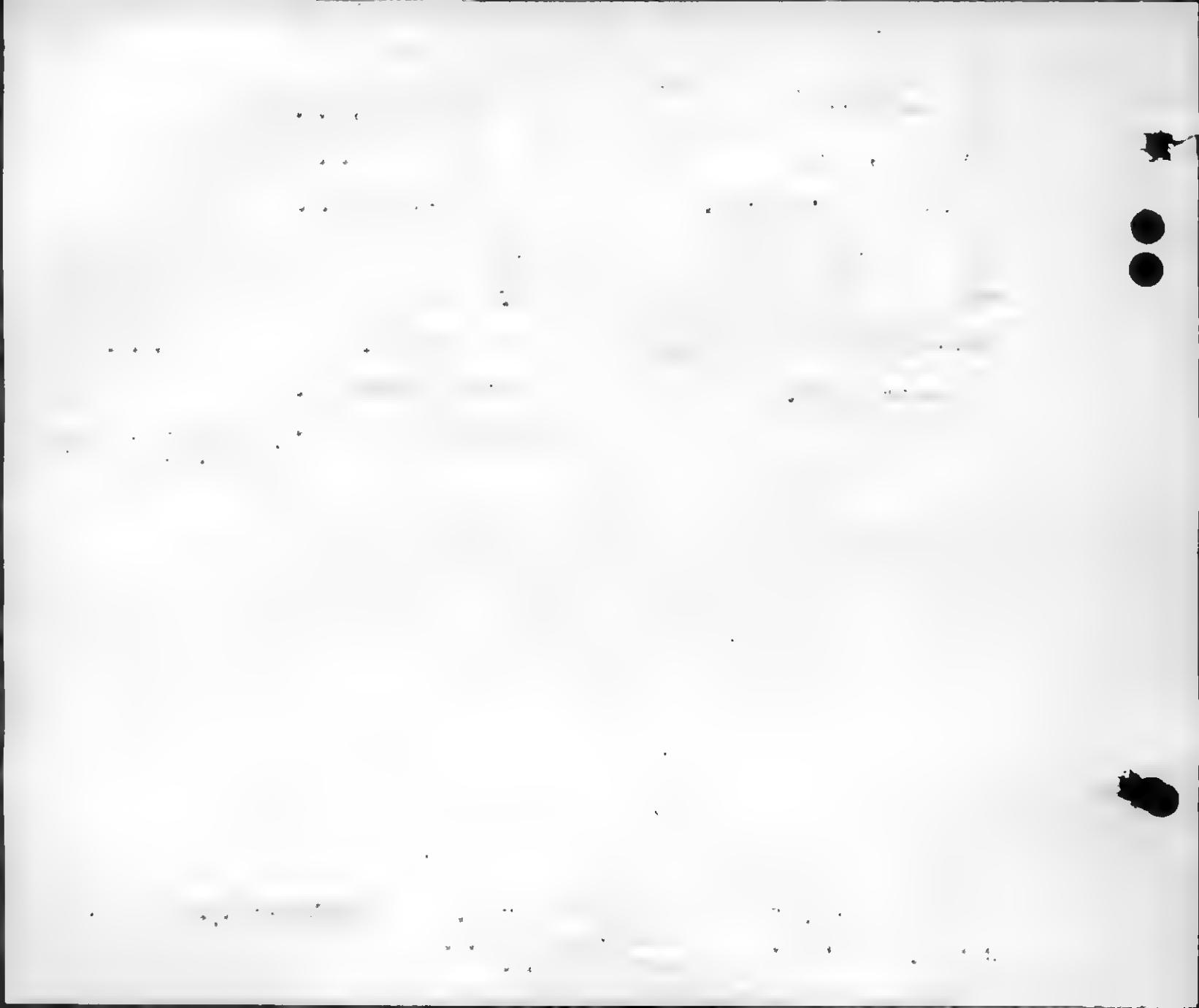
CERTIFICATE OF DEATH

Reg. Dist. No.

6987

TO HOSPITAL OR HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH CARROLL HALL REST HOME o. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WASHINGTON, D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON, MD		c. LENGTH OF STAY IN b 6 YRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL HALL REST HOME.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHANNA		First JOHANNA	Middle MERKEL
4. DATE OF DEATH JUNE 27 1961	Month JUNE	Day 27	Year 1961
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 4 1876
9. AGE (In years last birthday) 84 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) GERMANY.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME AUGUST RAULIN.		14. MOTHER'S MAIDEN NAME JOHANNA SHOEMACHER.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT MR FRED ERICK A RAULIN.	
		Address 13010 COLESVILLE ROAD SILVER SPRING MD BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS			
DUE TO ESSENTIAL HYPERTENSION			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO GENERALIZED ARTERIOSCLEROSIS (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) JENKIN	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 5206 N. Harvey St.	
(County) DISTRICT OF COLUMBIA		(State) MD	
21. I certify that I attended the deceased from DEC 6 1955 to JUNE 27 1961 , that I last saw the deceased alive on JUNE 27 1961 , and that death occurred at 7:10 AM , from the causes and on the date stated above			
ADDRESS (Street, city or town, state) Cherry Chase, Md			
DATE SIGNED 6/27/61			
ACTUAL SIGNATURE W.K. HUNTEMANN & SON.		PHYSICIAN'S NAME (Type) W.K. HUNTEMANN & SON.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/30/61	
22c. NAME OF CEMETERY OR CREMATORIAL CEDAR HILL CEMETERY.		22d. LOCATION (City, town, or county) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W.K. HUNTEMANN & SON.		24a. REG'D BY REGISTRAR ADDRESS 5732 GEORGIA AVE N.W. DATE JUN 29 61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6988

66974

CERTIFICATE OF DEATH

1. PLACE OF DEATH

e. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

5300 Westbard Avenue, Apt. 302 Westwood

3. NAME OF DECEASED First Middle

(Type or print)

Irene

Henry

Messall

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Female

White

WIDOWED DIVORCED

April 16, 1899

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Homemaker

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Own Home

Enid Ohio

13. FATHER'S NAME

Mr. Homer Henry Louisiana, Missouri

Elizabeth Russell

U.S.A.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

None

17. INFORMANT

Mr. Victor R. Messall Apt. 302 Westwood Apts.
5300 Westbard Avenue
Westwood, Md.

Kansas

Address

INTERVAL BETWEEN
ONSET AND DEATH

1 day

Coronary Occlusion

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY Month, Day, Year
Hour a.m. While at work Not While at work
p.m. 19

20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 6, 1961, to April 8, 1961, that (I) (we) last saw the deceased alive on April 8, 1961, and that death occurred at 8:30 AM, from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

JOHN J. CURRY

M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

22d. ADDRESS

22b. DATE SIGNED

6/8/61

10620 Georgia Ave

S.S. 14

(State)

23a. BURIAL, CREMATION, 23b. DATE THEREOF
REMOVAL (Specify)

Burial 16/12/61

23c. NAME OF CEMETERY OR CREMATORIAL

Parklawn Cemetery

23d. LOCATION (City, town or county)

Montgomery County, Maryland

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Warren E. Pumphrey, Inc.

ADDRESS
8434 Georgia Avenue
Silver Spring, Maryland

25a. REC'D BY REGISTRAR

DATE JUN 14 '61

25b. REGISTRAR'S SIGNATURE

Charles S. Kline

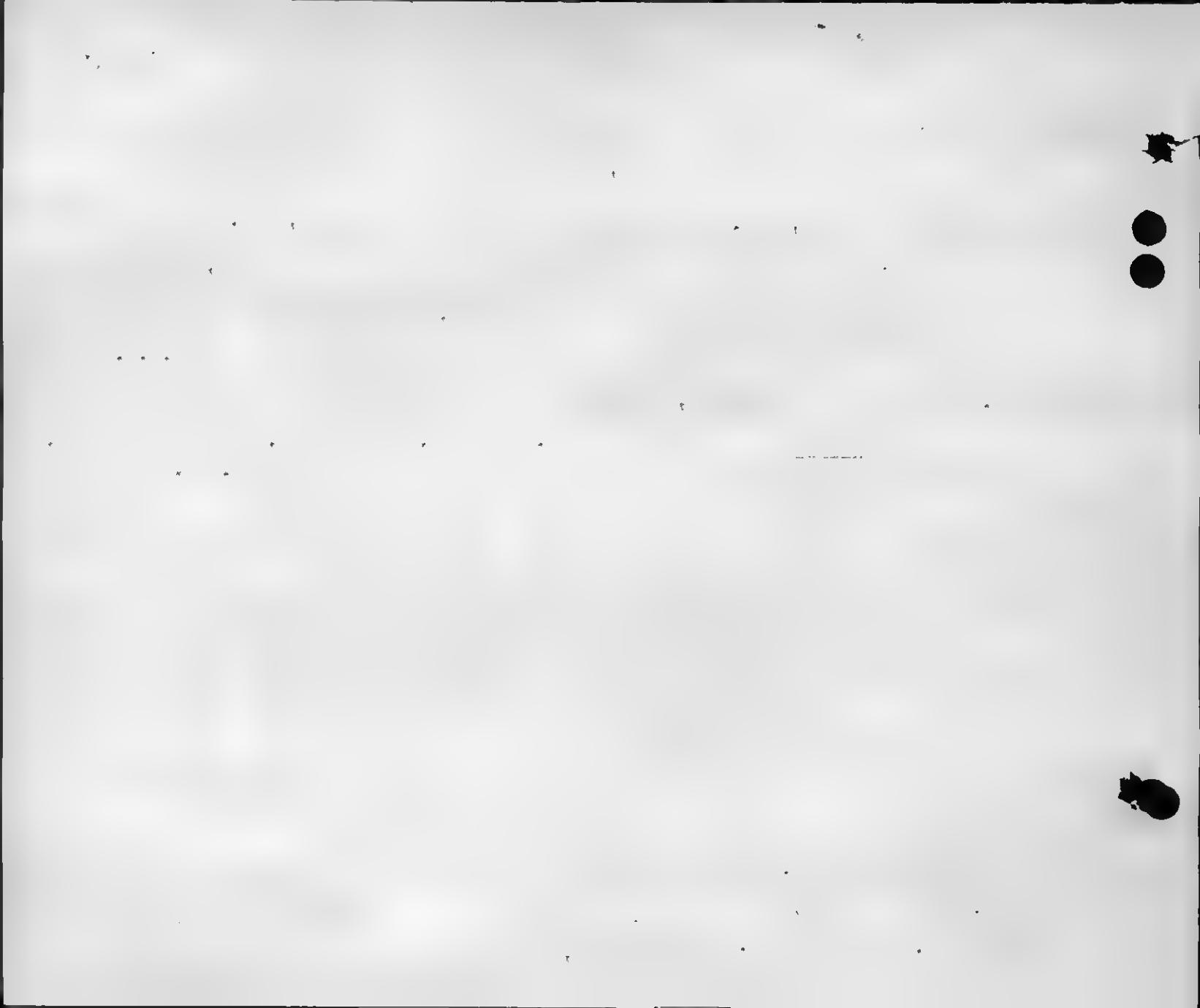
10 HOSPITAL DEATH. Page 4 must be retained by the hospital or attending physician.
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Within 24 hours after

M

I

VII A15 (4)
15M 9/60



TO HOSPITAL OR CLINIC: The law requires that the death certificate be executed within 72 hours after death.

TO PHYSICIAN: The law requires that the death certificate be signed by the attending physician and completely filed in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

6989

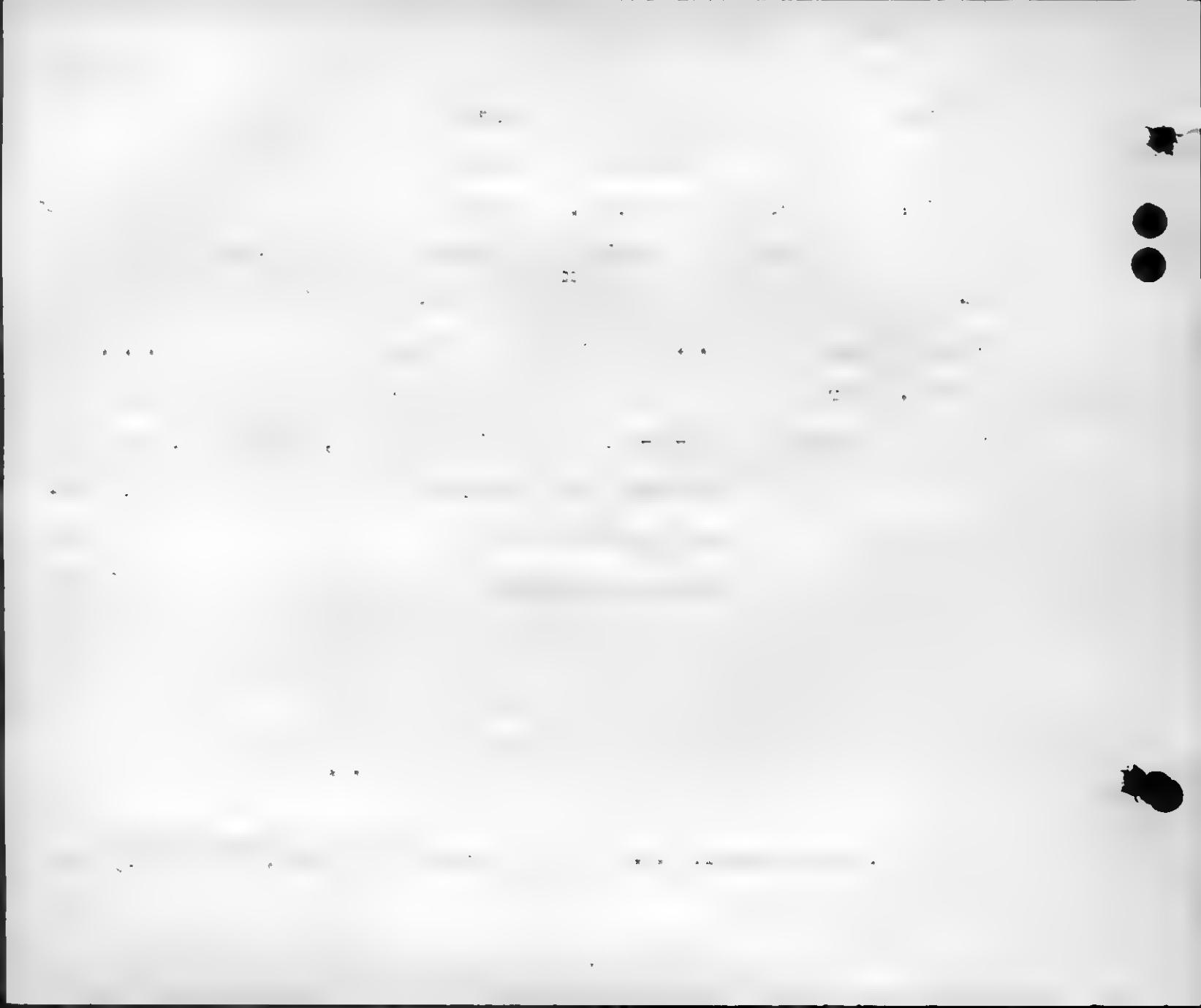
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06975

M

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE Indiana		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 27 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Haubstadt			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INST TUTION The Clinical Center, Bethesda 14, Md.		e. STREET ADDRESS Box 168		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Anna	Middle Louise	Last Meyer	4. DATE OF DEATH June 20 1961	Month June	Day 20	Year 1961
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH August 26, 1924	9. AGE (In years last birthday) 36 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Captain (Nurse)		10b. KIND OF BUSINESS OR INDUSTRY U.S. Air Force		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George J. Meyer				14. MOTHER'S MAIDEN NAME Anna Mayer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> Present		16. SOCIAL SECURITY NO 308-22-5118		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 12 hrs.							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Intestinal Obstruction 2 weeks							
DUE TO (b) Intestinal Obstruction 2 weeks							
DUE TO (c) Carcinoma of Rectum 3 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 20 1961, to June 20 1961, that (I) (we) last saw the deceased alive on June 20 1961, and that death occurred at 9:35 P.M. from the causes and on the date stated above							
22a. SIGNATURE <i>W. Walter Offelt</i>		M.D.		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 6/21/61	
22c. PHYSICIAN'S NAME (Type) W. WALTER OFFELT, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 24 JUNE 1961		23c. NAME OF CEMETERY OR CREMATORIAL HAUBSTADT Indiana		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>P. Offelt Funeral Home, Inc.</i>		ADDRESS 816 Hatfield Rd, NE DC		25a. REC'D BY REGISTRAR JUN 23 '61		25b. REGISTRAR'S SIGNATURE <i>William S. Kraus</i>	



TO HOSPITAL TENDING PHYSICIAN: The law requires that the death certificate be signed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

CORONER NOTIFIED AND WILL APPROVE.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

CERTIFICATE OF DEATH

06976

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
Montgomery		a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		b. COUNTY Washington	
Silver Spring		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		Chagers town	
2224 Washington Avenue		d. STREET ADDRESS	
First		3. LENGTH OF STAY IN lb	
Irvin		4 days	
Ray		4. DATE OF DEATH	
Middlekauff		June	14
5. SEX		5. COLOR OR RACE	
Male		White	
6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (in years last birthday) IF UNDER 1 YEAR	
Nov. 25, 1883		77 yrs	Moths 6 Days 9
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. KIND OF BUSINESS OR INDUSTRY	
Retired		12. C.TIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		Maryland USA	
Daniel J. Middlekauff		Amelia Margaret Downin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOC AL SECURITY NO		17. INFORMANT	
(Yes, no, or unknown) (If yes, give rank and dates of service)		Address	
No		619-30-1468 Stella Middlekauff-wife-same 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		26 HRS.	
C 32 X DUE TO		CEREBRAL THROMBOSIS	
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause test.		ANTERIOSCLEROSIS GENERALIZED	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		19. WAS AUTOPSY PERFORMED?	
20e. ACCIDENT WAS UNDERLYING CAUSE OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from ... 13 Jun. 1961 to ... 14 Jun. 1961 that (I) (we) last saw the deceased alive on ... 13 June 1961, and that death occurred at ... 1020 AM from the causes and on the date stated above.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
L. Marshall Cuvillier, Jr		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		6/16/61	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City, town or county) (State)	
Rose Hill Cemetery		Hagerstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE		25e. REC'D BY REGISTRAR	
Andrew K. Goffman Hagerstown, Maryland		DATE JUN 19 '61	
		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6991

CERTIFICATE OF DEATH

06975

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN lb

16 18

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Suburban

First

Middle

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)

a. STATE

D.C.

b. COUNTY

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Washington

d. STREET ADDRESS

1417 N. St., N.W. Apt 500

Last Month Day Year

e. IS RESIDENCE ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

Salvatore John

First

Middle

4. DATE
OF
DEATH

6

27

19 61

5. SEX

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

10/12/17

9. AGE (In years
last birthday) IF UNDER 1 YEAR

43 yrs.

Months Days

IF UNDER 24 HRS.
Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

JOHN MISTRETTA

14. MOTHER'S MAIDEN NAME

MILLIE HALL

Address 343 1/1

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17
(Yes, no, or unknown) (If yes, give war or date of service) 577-10-9302

18. CAUSE OF DEATH (Enter only one cause preceding for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

(b)

DUE TO

(c)

Respiratory Failure

Breast cancer several months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While at work
p.m. 19 Not While at work

20d. INJURY OCCURRED
20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 4/15/61 to 6/27/61, that (I) last saw the deceased alive on 6/27/61, and that death occurred at 2 P.M. from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

23a. BURIAL, CREMATION,
REMOVAL (Specify)
URISI

23b. DATE THEREOF
6-30-61

24 FUNERAL DIRECTOR'S SIGNATURE

J. Hollings

ADDRESS 434 P.T.C.

1411

23c. NAME OF CEMETERY OR CREMATORIAL
ARLINGTON NATIONAL

23d. LOCATION (City, town or county)

(State)

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22d. ADDRESS

WASHINGTON CLINIC

6/27/61
22b. DATE
SIGNED

25a. REC'D BY REGISTRAR

JUN 30 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Keay

hours after
within

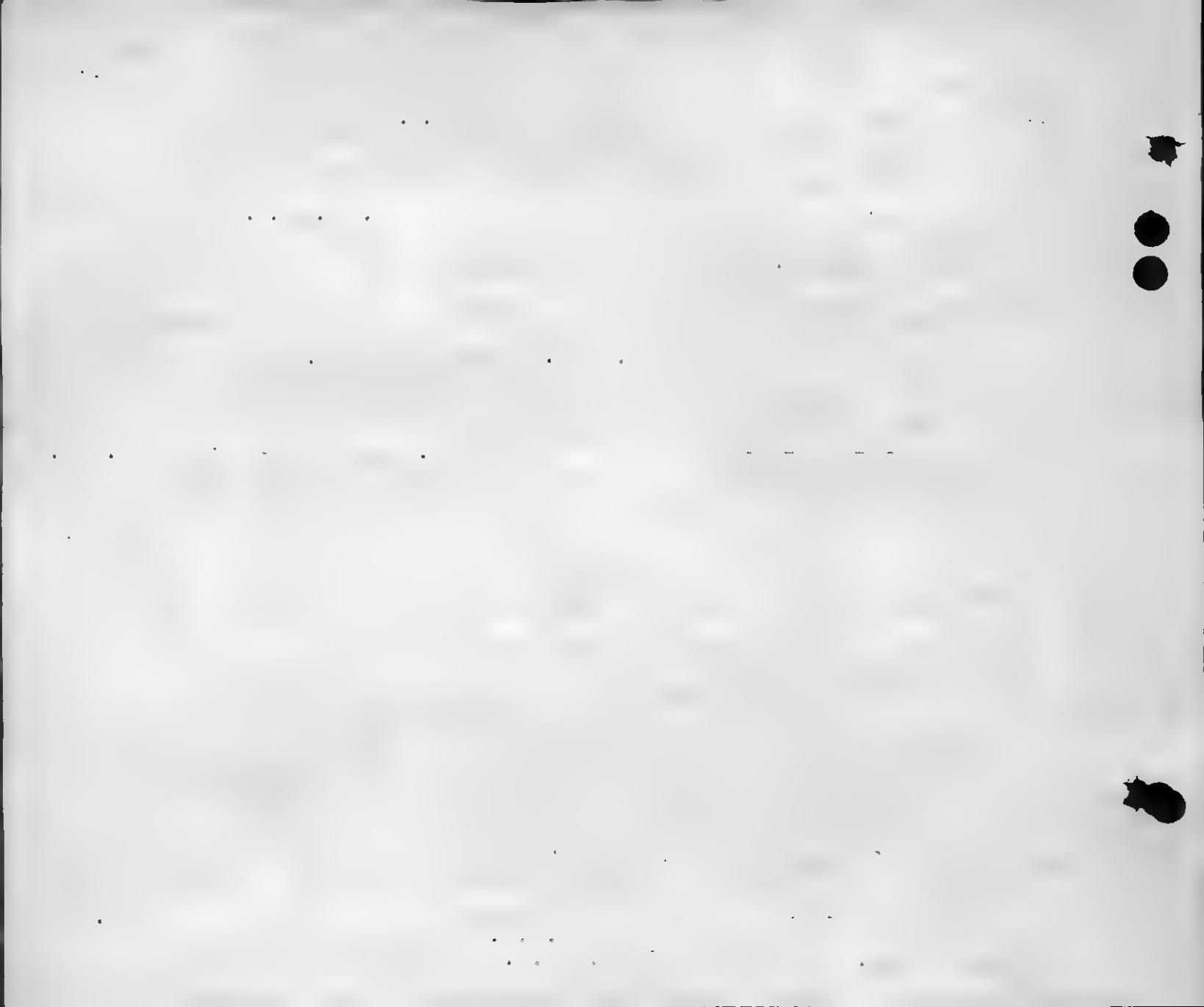
death. Page 4
be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral

director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should

be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60



12

TO HOSPITAL _____ **ATTENDING PHYSICIAN:** The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6992

CERTIFICATE OF DEATH

C6979

1. PLACE OF DEATH
e. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Chevy Chase

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

7110 - 45th Street

3. NAME OF
DECEASED
(Type or print)

CLARA

First

MARYLAND

c. LENGTH OF STAY IN HB

Middle

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)

e. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Chevy Chase

d. STREET ADDRESS

7110 45th Street

Last

4. DATE
OF
DEATH

Month

Day

Year

June 7, 1961

e. IS RESIDENCE
ON A FARM?
YES NO

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (in years) UNDER 1 YEAR
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife

11. KIND OF BUSINESS OR INDUSTRY

12. BIRTHPLACE (County & State or foreign country)
Tonica, Illinois

13. CITIZEN OF WHAT COUNTRY?
U.S.A.

MORRIS

92 yrs

10. AGE (in years) UNDER 1 YEAR
11. BIRTHPLACE (County & State or foreign country)
Tonica, Illinois

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

14. MOTHER'S MAIDEN NAME

Sarah J. Potter

Address

Alta Marie Morris same as #2

13. FATHER'S NAME

William B. Boyley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

none

Alta Marie Morris

INTERVAL BETWEEN
ONSET AND DEATH
2 days

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY;
IMMEDIATE CAUSE (a)

Bronchial pneumonia

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Senile dementia

Cerebral & generalized arterio-sclerosis

4 mos.

10 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY
PERFORMED?

YES NO

20a. MEDICAL CERTIFICATION

20b. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m.

20d. INJURY OCCURRED While Not While
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Aug-Dec 1959, to 7 June 1961, that (I) (we) last saw the deceased alive on 6 June 1961, and that death occurred at 12:35 P.M. from the causes and on the date stated above.

22a. SIGNATURE

John G. Ball

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED

22c. PHYSICIAN'S
NAME (Type)

John G. Ball, M.D.

7936 Georgetown Rd., Bethesda, Md.

23a. BURIAL, CREMATION OR REMOVAL (Specify)

removal 6/8/61

23b. DATE THEREOF

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

The S.H. Hines Co.

25a. ADDRESS

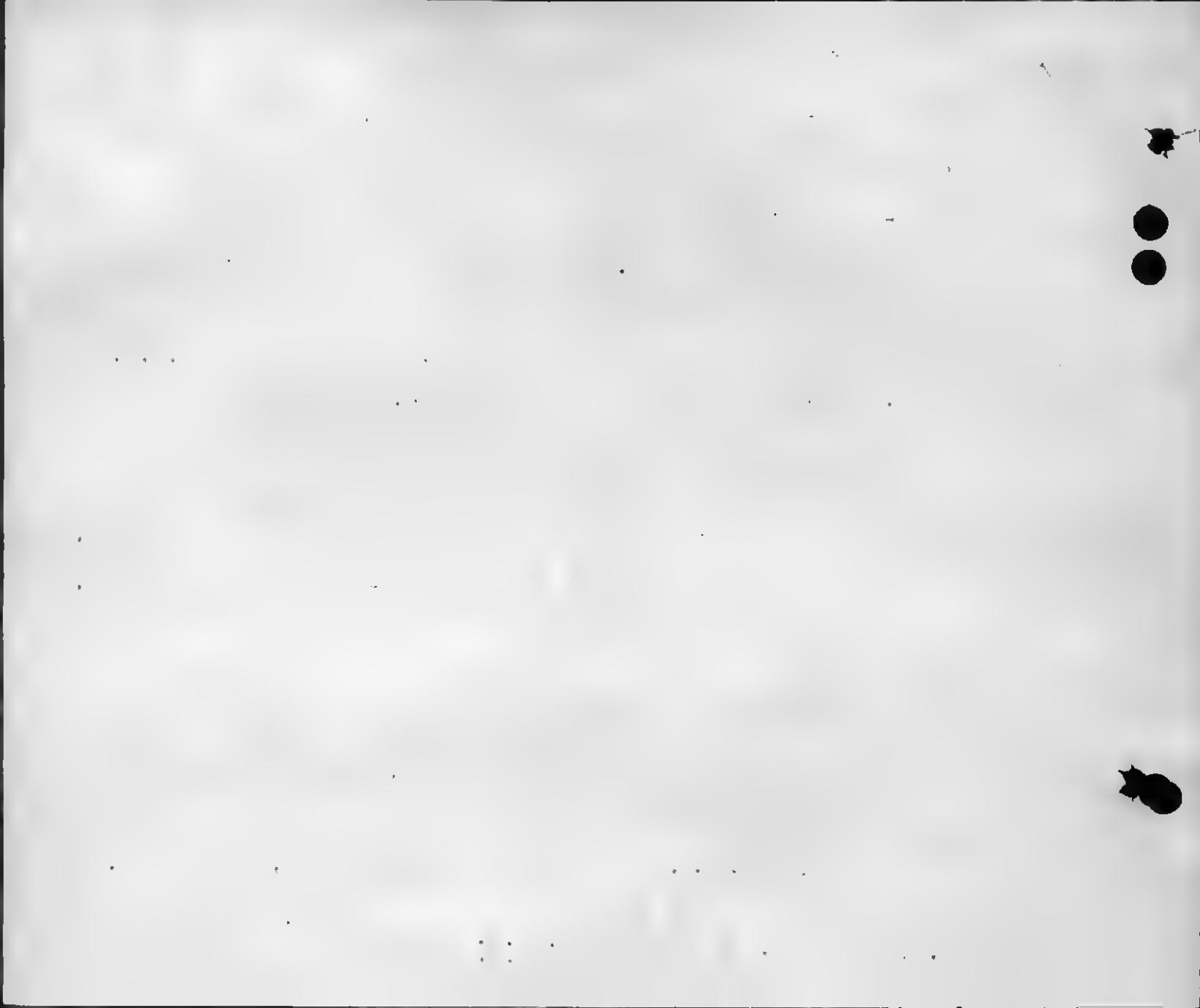
**2901 14th St. N.W.
Washington 9, D.C.**

25b. REC'D BY REGISTRAR

JUN 8 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus



TO HOSPITAL or **ATTENDING PHYSICIAN:** The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4 may be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6993

66980

CERTIFICATE OF DEATH

1. PLACE OF DEATH
e. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Wheaton, Md.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Wheaton Nursing Home

3. NAME OF DECEASED
(Type or print)

LILLIE

First

MARYLAND

c. LENGTH OF STAY IN lb

5/21/61

5. SEX

6. COLOR OR RACE

Female

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

13. FATHER'S NAME

William Hartman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT
(Yes, no, or unknown) (If yes give war or dates of service)

no

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

33IX

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause test.

(b)

DUE TO

(c)

none Mrs. Elsie M. Bixler -Washington, D.C.

MOURER

Last

4. DATE
OF
DEATH

Month

Day

Year

6

21

19 61

B. DATE OF BIRTH

7/1/1865

95

yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Carlisle, Pa.

U.S.A.

14. MOTHER'S MAIDEN NAME

Amelia Guise

Address 6348-31st Pl. NW

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
p.m. While at work Not White 20f. (City or town)
19 at work at work

(County) (State)

21. I certify that (I) (this hospital) attended the deceased from 19 .. to 19 .., that (I) (we) last saw the deceased alive on 19 .., and that death occurred at M, from the causes and on the date stated above.

22e. SIGNATURE

Harry N. Carlton

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS. 22b. DATE
SIGNED
6/21/6122c. PHYSICIAN'S
NAME (Type)

Harry N. Carlton

22d. ADDRESS

1522 Flora Ct. Sil. Sp. Md.

23e. BURIAL, CREMATION, DATE THEREOF
REMOVAL (Specify)

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county)

(State)

Burial 16/24/61

Westminster Cemetery

Carlisle, Penna.

24 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25e. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

The S. H. Hines Company-Washington, D.C.

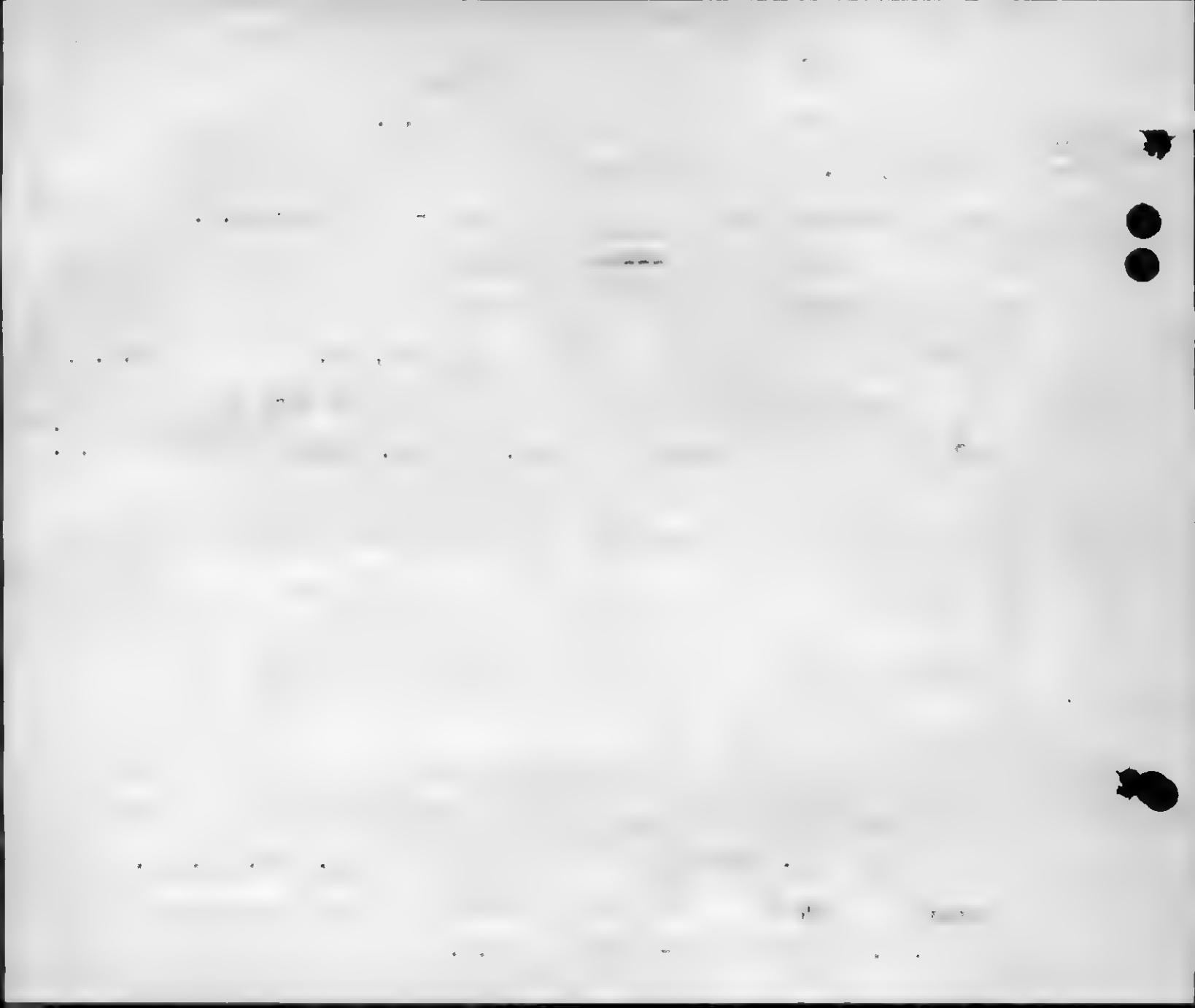
DATE JUN 23 '61

Arthur S. Kraus

within 24 hours after

M

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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6394

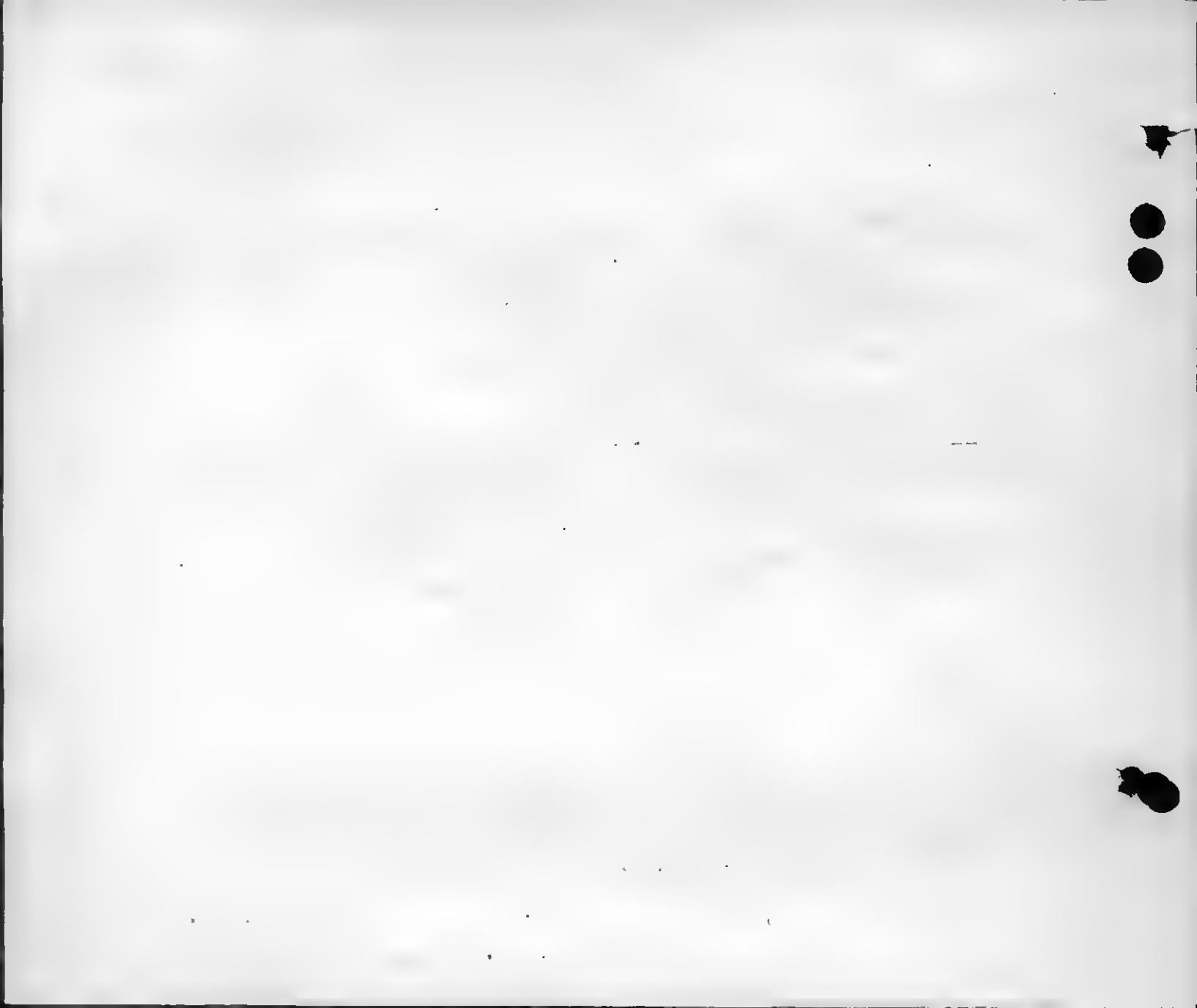
06981

Page 4

M

TO HOSPITAL OR
 may be required by
TO FUNERAL DIRECTOR
 after the funeral director,
 this certificate has been signed by the attending physician and completely filled out.
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 25 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLARKSBURG		d. STREET ADDRESS R-121		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First LULA	Middle M.	Last NEWMAN	4. DATE OF DEATH	Month JUNE	Day 12,	Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 4-22-1895	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME WILLIAM E. SMITH				14. MOTHER'S MAIDEN NAME LAURA O. Ogle				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT Address HOSPITAL RECORDS, OLNEY, MARYLAND				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis, Launcet's one Month DUE TO 381-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) of Liver DUE TO (c) Bronchopneumonia, Bilateral INTERVAL BETWEEN ONSET AND DEATH PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 5-18-1961 to 6-12-1961 , that (I) (we) last saw the deceased alive on 6-11-1961 , and that death occurred at 3 a.m. from the causes and on the date stated above.								
22a. SIGNATURE <i>Jack Schumacher</i>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1961				
22c. PHYSICIAN'S NAME (Type) JACK SCHUMACHER, M. D.		22d. ADDRESS GAITHERSBURG, MARYLAND						
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF June 15, 1961		23c. NAME OF CEMETERY OR CREMATORIAL Little Vine		23d. LOCATION (City, town, or county) Sylvatus, Va.		
24. FUNERAL DIRECTOR'S SIGNATURE <i>Olm L. McLean</i>		ADDRESS Damascus, Md.		25a. REC'D BY REGISTRAR DATE JUN 14 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>		



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06982

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write BURAL and give nearest town)

Akoma Park

c. LENGTH OF STAY IN lb

14 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington Gen & Hosp

3. NAME OF
DECEASED
(Type or print)

First

Middle

5. SEX

Female

6. COLOR OR RACE

Negro

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

maid.

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

10b. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

JAMES MOORE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

710

Pt Chark

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

CARDIAC TAMPOURDE

022X
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

RUPTURED AORTIC ANEURYSM

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Hour e.m. p.m.	Month, Day, Year 19
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

21. I certify that (I) (this hospital) attended the deceased from MAY 21, 1961, to JUNE 4, 1961, that (I) (we) last saw the deceased alive on JUNE 3, 1961, and that death occurred at 7:48 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Morrill C. Quinnam Jr.

M.D.

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

22b. DATE SIGNED

5-4-61

22c. PHYSICIAN'S NAME (Type)

Morrill C. Quinnam Jr.

22d. ADDRESS

7600 CARROLL AVE. THOMAS PARK, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

6/9/1961

23c. NAME OF CEMETERY OR CREMATORIAL

Ship To -

23d. LOCATION (City, town or county)

Scotland Neck, North Carolina

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

John R. Parker ADDRESS 653
W. Ernest Jarvis Co. 1432 You St., N.W.

25a. REC'D BY REGISTRAR DATE

JUN 15 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Thorne



TO HOSPITAL OR
may be retained by
TO FUNERAL DIRECTOR
After this certificate has been signed by the attending physician and completely filled in,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6995

C6983

Item 9 #1 in G260

1. PLACE OF DEATH

o. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Clyde

c. LENGTH OF STAY IN lb

3 yrs 2 mo

d. NAME OF HOSPITAL (If not in hospital, give street address)

OR INSTITUTION

Brooke Grove Funeral Inc

3. NAME OF DECEASED

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

Female

W

WIDOWED

DIVORCED

sept. 4 1874

1874

yrs

9. AGE (In years last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS

Months

Days

Hours

Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

School teacher

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ohio

12 CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John H. Oberly

14. MOTHER'S MAIDEN NAME

Aleen Suckers

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unknown)

(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

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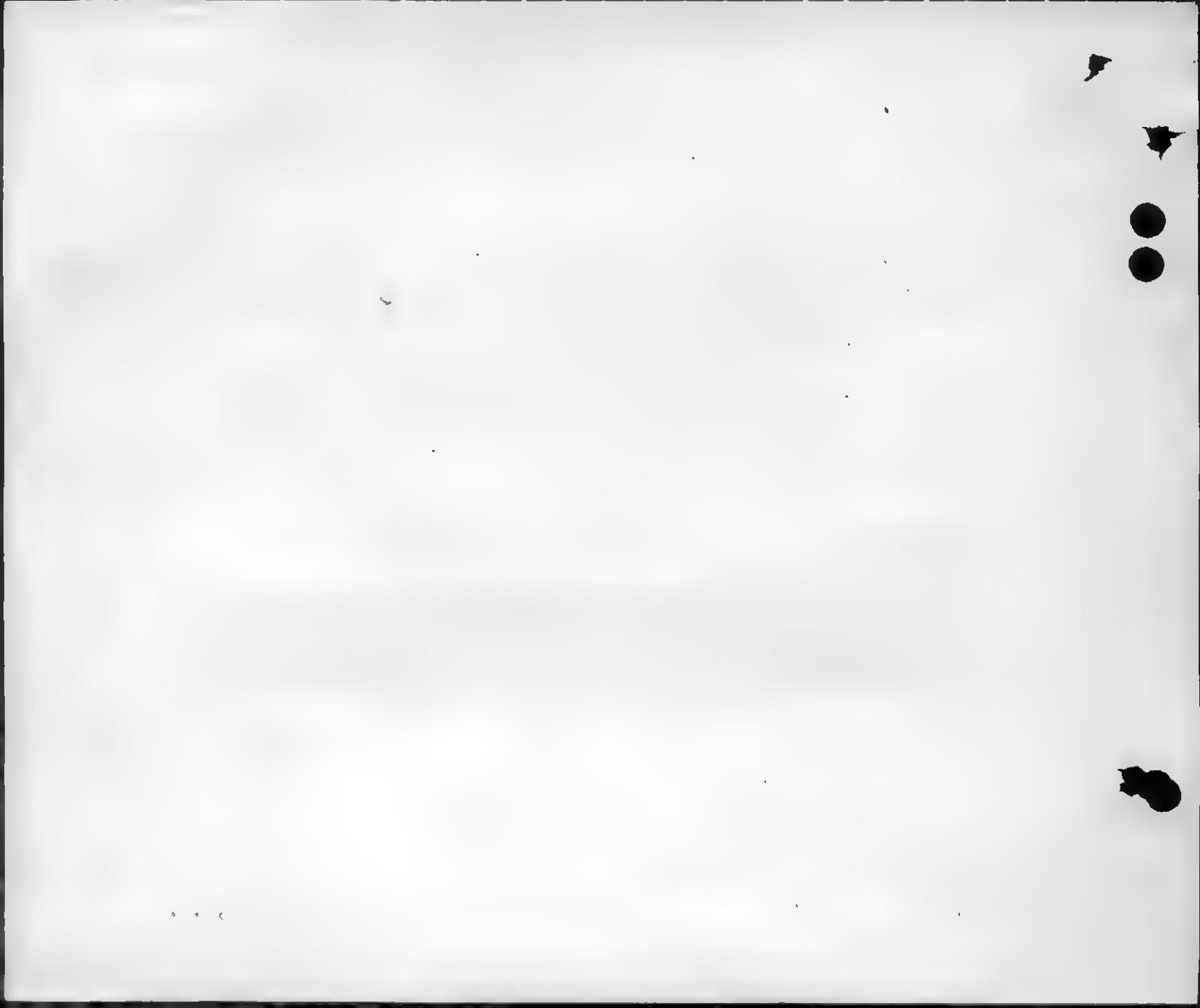
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TO HOSPITAL OR
may be retained by
TO FUNERAL DIRECTOR after this certificate has been signed by the attending physician and completely filled in by the funeral director.
Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

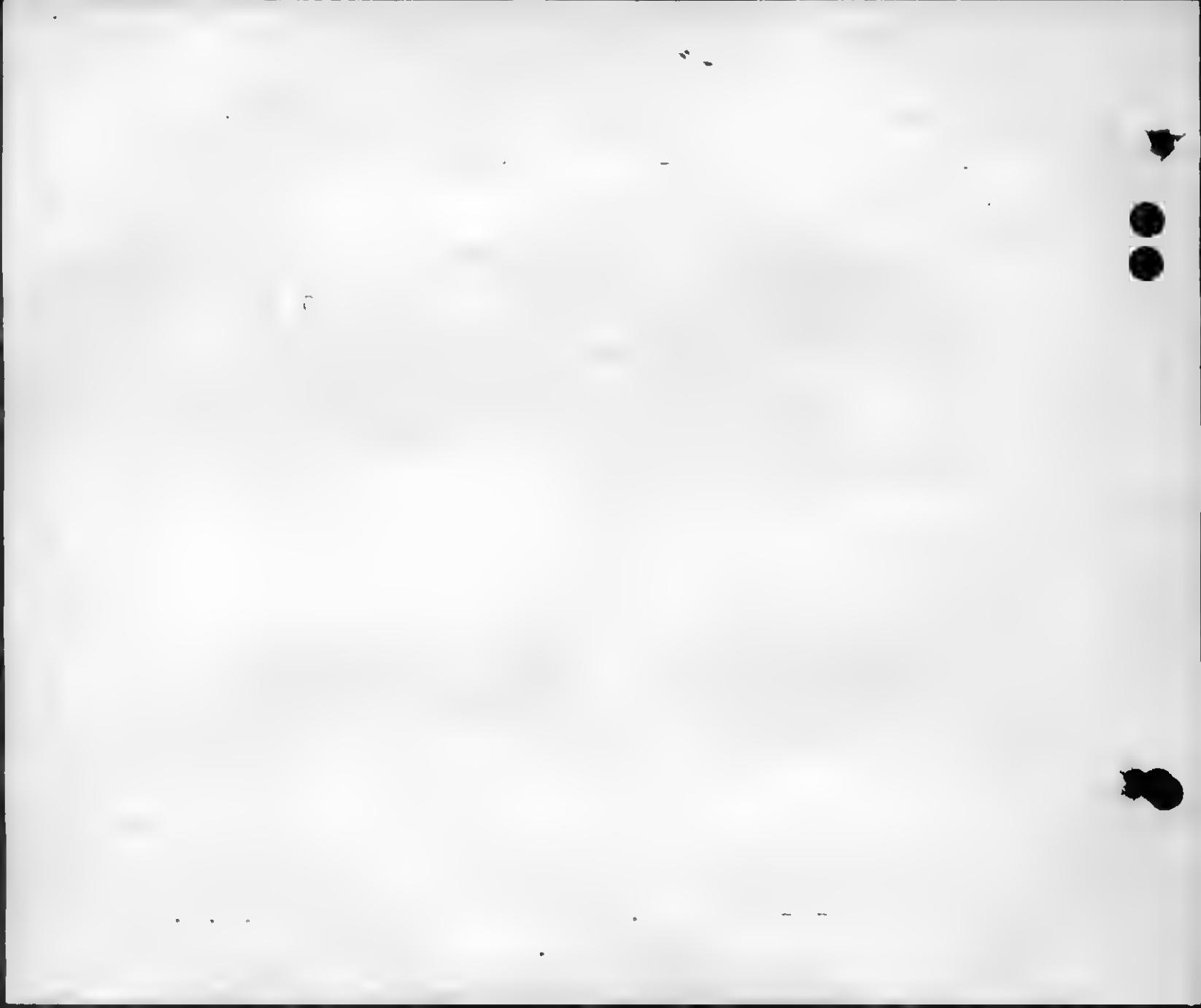
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

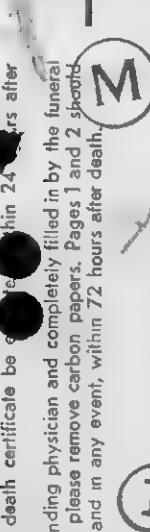
06984

6997		M		073		1	
1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN lb —		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norwood Rd.		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Loretta	Middle NMN	Last O'Connell	4. DATE OF DEATH 6 24 1961		Month Day Year
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/23/78	
						9. AGE (In years last birthday) 83 yrs.	
						IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Washington, DC		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jermiah O'Connell				14. MOTHER'S MAIDEN NAME Eleanor Costello			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO unknown		17. INFORMANT Hospital Records		Address Olney, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Jeremiah</i>							
422. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic myocarditis & failure</i> DUE TO <i>3 months</i> (c) <i>Cerebrovascular accident</i> DUE TO <i>3 months</i> (d) <i>Arteriosclerosis</i> DUE TO <i>15 yrs</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Fatty liver 4/15/61</i>							
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)					
20c. TIME OF INJURY Month, Day, Year Hour p. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>June 24</i> , 1961, to <i>June</i> , 1961, that (I) (we) last saw the deceased alive on <i>June 24</i> , 1961, and that death occurred at <i>8:58 AM</i> , from the causes and on the date stated above							
22a. SIGNATURE <i>Dr. A.D. Bonifant</i>				22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) Dr. A.D. Bonifant			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-27-61		23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet		23d. LOCATION (City, town, or county) Washington, D. C. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Francis K. Barber</i>		ADDRESS Laytonsville, Md.		25a. REC'D. BY REGISTRAR JUN 29 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



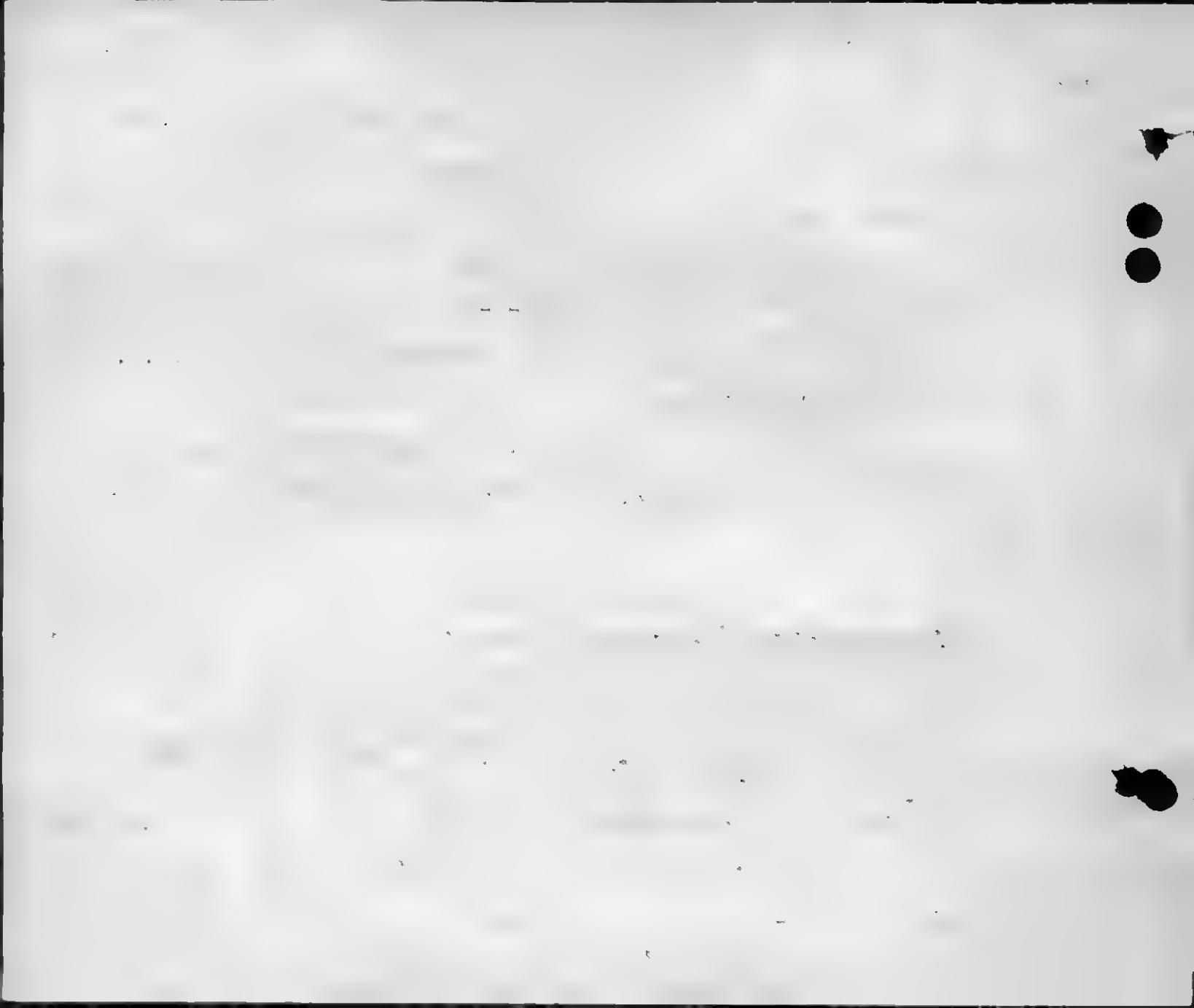
**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

CERTIFICATE OF DEATH

6985

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)	
Montgomery				a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 16		b. COUNTY Frederick	
Rockville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Brunswick			
324 Cedar Lane		d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	
Edna		Gertrude	Pace	6	Month
5. SEX		6. COLOR OR RACE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	Day
Female		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	10-1-1893	Year
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)	
House wife		Home		67	IF UNDER 1 YEAR Months Days Hours Min.
13. FATHER'S NAME		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
George Forrest		Maryland		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <input checked="" type="checkbox"/> If yes give rank or dates of service)		16. SOCIAL SECURITY NO.		Sarah Keontz Address	
N				Mrs. Leis Nuse, Rockville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		17. INFORMANT		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO		Adenocarcinoma of Endometrium 1-2 yrs	
172X					
Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. } (b)		DUE TO			
{					
(a), stating the underlying cause last. } (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		19. WAS AUTOPSY PERFORMED?			
Esophageal Diathermy		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
19					
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on... 6/7 1961		4/24 1961 to 6/10 1961		that (I) (we) last death occurred at 6 A.M. from the causes and on the date stated above.	
22a. SIGNATURE		ATTENDING PHYS. M.D. <input checked="" type="checkbox"/>		22b. DATE SIGNED 6/10/61	
Arthur F. Woodward		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		Rockville - Md.	
Arthur F. Woodward					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23d. LOCATION (City, town or county) (State)	
Burial		6-12-1961		Brunswick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR	
B. E. T. Brunswick, Maryland				25b. REGISTRAR'S SIGNATURE Arthur S. Kline	
				DATE JUN 13 '61	

VIII A15 (4)
15M 9/60



1

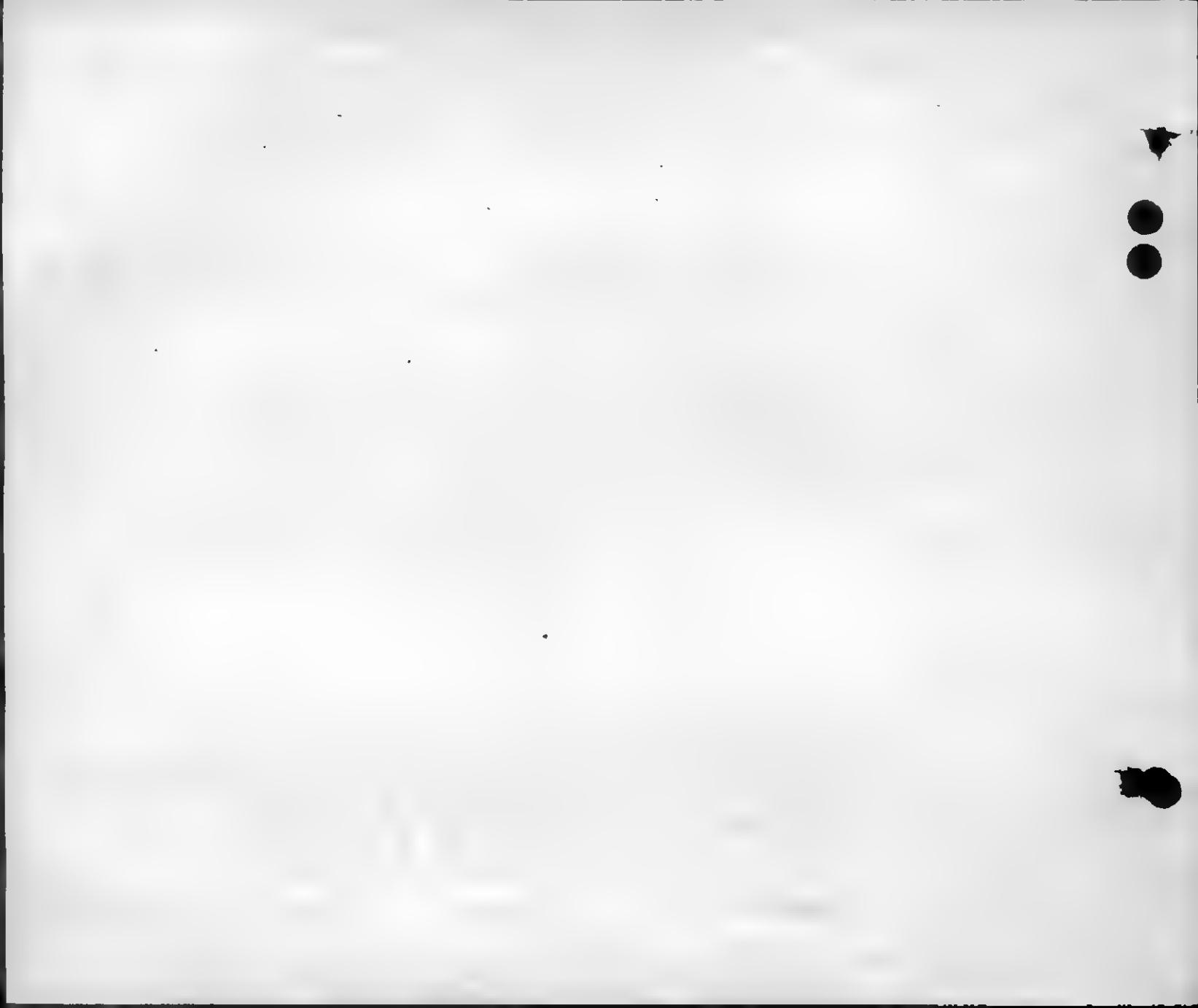
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours of the time of death. After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06986

1. PLACE OF DEATH D. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) G. STATE J. COUNTY	
<i>Montgomery Maryland</i>		<i>Dist. of Columbia</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Bethesda</i>	<i>10 hrs. 50 min.</i>	<i>Washington D.C.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
<i>Suburban</i>	<i>4617-42nd St. N.W.</i>		
3. NAME OF DECEASED (Type or print)	First	Middle	Last
<i>Rose M. Parenteau</i>			
4. DATE OF DEATH	Month	Day	Year
<i>June 9 1961</i>			
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
<i>Female</i>	<i>white</i>	<i>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></i>	<i>6/13/98</i>
9. AGE (In years last birthday) yrs	10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS	
<i>67 yrs</i>			
10a. USAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<i>Housewife</i>		<i>Minn.</i>	<i>U.S.A.</i>
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
<i>Jefferson Porter</i>	<i>Philomene Emard</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address <i>4617-42 S.E. NW</i>
No	<i>579-42-1237</i>	<i>Edward W. Parenteau</i>	<i>Wash. DC</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
<i>Circulatory Failure</i>			
INTERVAL BETWEEN ONSET AND DEATH			
420.1			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) <i>Hypocardial Infarction</i>			
(c) <i>Coronary Occlusion</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from <i>June 8 1961</i> to <i>June 9 1961</i> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <i>June 9 1961</i> , and that death occurred at <i>7:40 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Elaine A. Murphy MD</i>		22b. DATE SIGNED <i>6-10-61</i>	22c. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>E. Murphy</i>		22d. ADDRESS <i>4812 Ellicott St NW</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>June 13 1961</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Nat'l of Veterans</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Chase General Homecare D.C.</i>		23d. LOCATION (City, town, or county) <i>Ga. Ave. Silver Spring Md</i>	(State)
		25a. ADDRESS <i>500 3rd ave.</i>	25b. REC'D BY REGISTRAR DATE JUN 14 '61
			REGISTRAR'S SIGNATURE <i>Arthur S. Hunt</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death by the attending physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

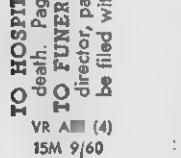
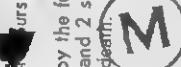
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06987

7000			
1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE West Va.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Roxbury		b. COUNTY Clarksburg	
c. LENGTH OF STAY IN 1b 5 Wks.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gates	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens San.		d. STREET ADDRESS 4323 Parrill Court	
3. NAME OF DECEASED (Type or print) Dorsey H. Parrill		First	Middle
4. DATE OF DEATH 6 23 1961		Last	Month
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 9-28-75		9. AGE (In years last birthday) 85 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY — — — —	
11. BIRTHPLACE (State or foreign country) West. VA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph P. Parrill		14. MOTHER'S MAIDEN NAME Hannah Foley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. — — — —	
17. INFORMANT D.H. PARRILL, 2139-WISC. AVE. N.W.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X <i>Consolidating fld. abling - (poss. malign.)</i> DUE TO 1 yr Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio-sclerotic ht disease c. peric fib.</i> DUE TO 2 yrs. (c) <i>Urinary infection assoc. c. prostatism</i> DUE TO 5 mos.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Clarksburg (County) W. Va. (State) W. Va.	
21. I certify that (I) (this hospital) attended the deceased from 5/13 , 1961, to 6/23 , 1961, that (I) (we) last saw the deceased alive on 6/22 1961 , and that death occurred at 3 AM , from the causes and on the date stated above.		22. SIGNATURE Marvin Wadler M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b. DATE SIGNED 6/23/61	
22c. PHYSICIAN'S NAME (Type) MARVIN WADLER		22d. ADDRESS 8218 WISCONSIN AV. BETH.	
23a. BURIAL, CREMATON, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 6-23-1961	
23c. NAME OF CEMETERY OR CREMATORIAL BRIDGEPORT CEMETERY		23d. LOCATION (City, town, or county) Clarksburg, W. Va. (State) W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph E. Wadler, Inc. 1756 Pa. Ave. NW.		25a. ADDRESS 1756 Pa. Ave. NW.	
25b. REC'D BY REGISTRAR Book 615		25c. REG STRR'S SIGNATURE Univer 8 June	
DATE JUN 26 '61			



TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the physician or attending physician, it may be retained by the hospital or funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4 may be filed with the State Dept. of Health within 24 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

CERTIFICATE OF DEATH

06983

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Kensington

c. LENGTH OF STAY IN 1b

MARYLAND

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

9804 E. Bexhill Drive

3. NAME OF
DECEASED
(Type or print)

First

Middle

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

W.DOWED

DIVORCED

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Oct. 22, 1893

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State or foreign country)

Indiana

13. FATHER'S NAME

Louis Harrell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Unknown

Address

Alma Burt

Kent Paxton-Husband-Same Item #2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
(IMMEDIATE CAUSE (a))

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause first.

DUE TO

(b)

DUE TO

(c)

THROMBOSIS OF BASILAR ARTERY
CEREBRAL ARTERIOSCLEROSIS

INTERVAL BETWEEN
ONSET AND DEATH
3 HOURS

1 YEAR

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY
PERFORMED?
YES NO

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While at work
p.m. 19 Not While at work

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (This Hospital) attended the deceased from July 10, 1948 to June 7, 1961, that (I) (We) last saw the deceased alive on June 7, 1961, and that death occurred at 10 A.M. from the causes and on the date stated above.

22a. SIGNATURE

Thomas S. Sappington, M.D.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Bur-transit | 6/8/1961

24. FUNERAL DIRECTOR'S SIGNATURE

Robert A. Pumphrey

23c. NAME OF CEMETERY OR CREMATORIUM

West Point Cemetery

ADDRESS

Bethesda, Maryland

M.D. ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22d. ADDRESS

1025

WASH. D.C.

JUNE 7, 1961

CONNECTICUT AVE. NW

STATE

LIBERTY

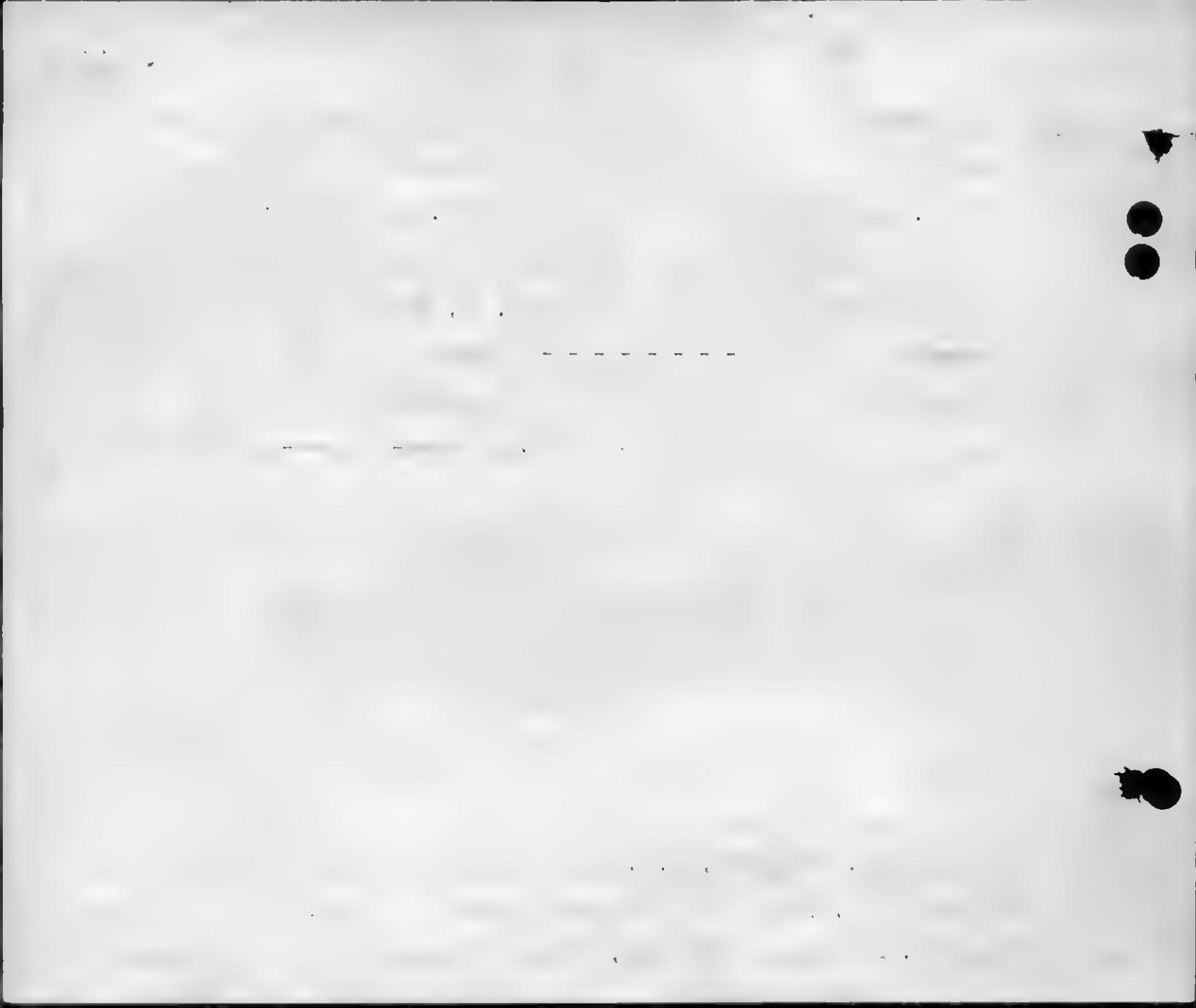
INDIANA

25e. REC'D BY REGISTRAR

JUN 9 '61

Arthur S. Kraus

25b. REGISTRAR'S SIGNATURE



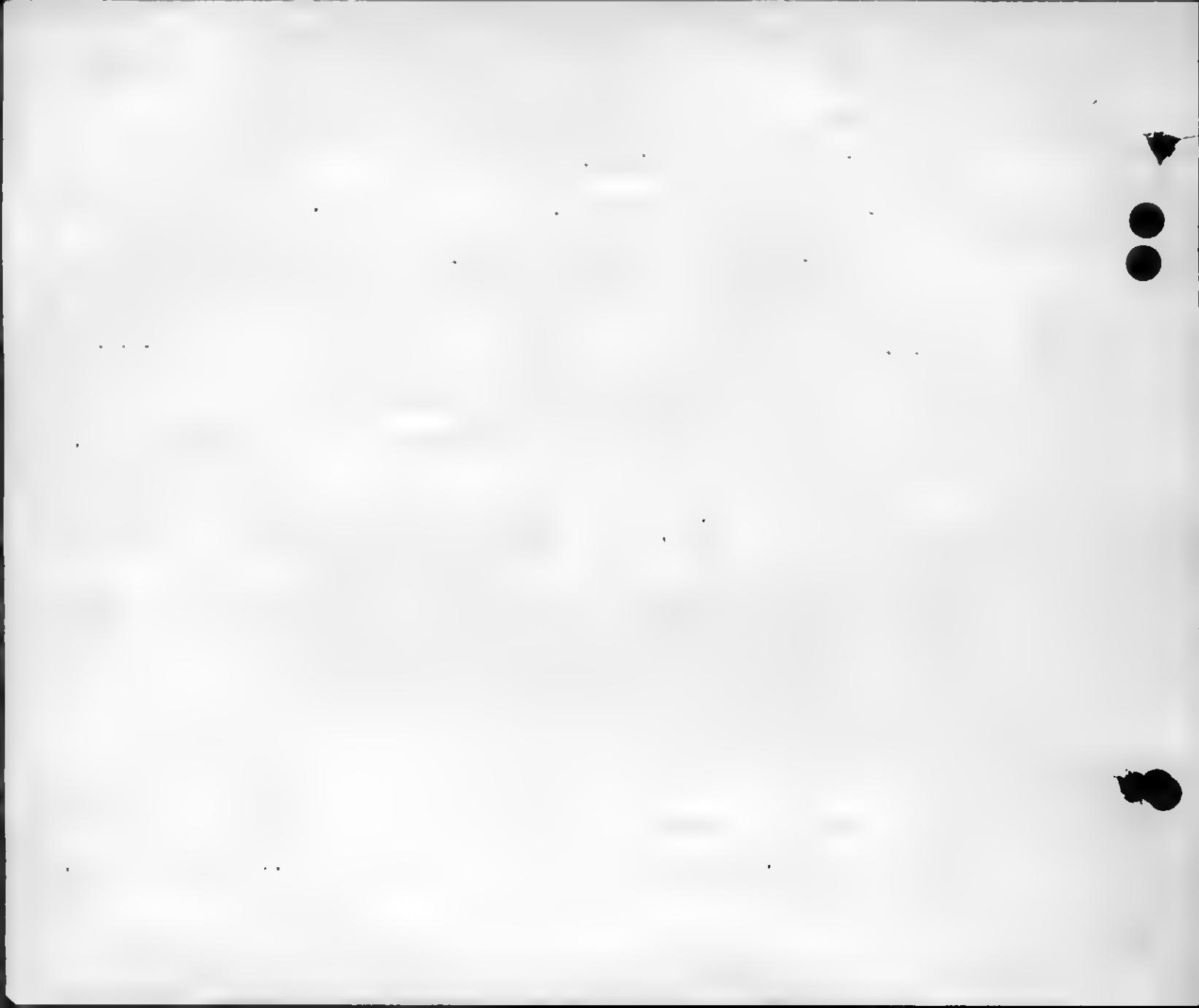
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7002 C6983

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN Tb 11½ yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 516 Marietta St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home for the Aged, Inc.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Cora	Middle Lee	Last Payne	4. DATE OF DEATH June 27	Month Year 1961	Day Year
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1878		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Perry Weimer			14. MOTHER'S MAIDEN NAME Catherine Zebauch		Address Asbury Methodist Home, Gaithersburg, Md.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. none		17. INFORMANT		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) +20.0 Conditions, if any which gave rise to immediate cause (a), stating the under- lying cause last.			DUE TO (b) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 5 minutes		
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 2-2 1961 to 6-27 1961, that (I) (we) last saw the deceased alive on 6-22 1961, and that death occurred at 2:30 PM, from the causes and on the date stated above.						22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) James W. Egan			M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				
22d. ADDRESS 7720 Wisconsin Ave., Bethesda 14, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 29, 1961		23c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		23d. LOCATION (City, town, or county) Cumberland, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Byron Kight			ADDRESS Cumberland, Md.			25a. REC'D BY REGISTRAR DATE JUL 3 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

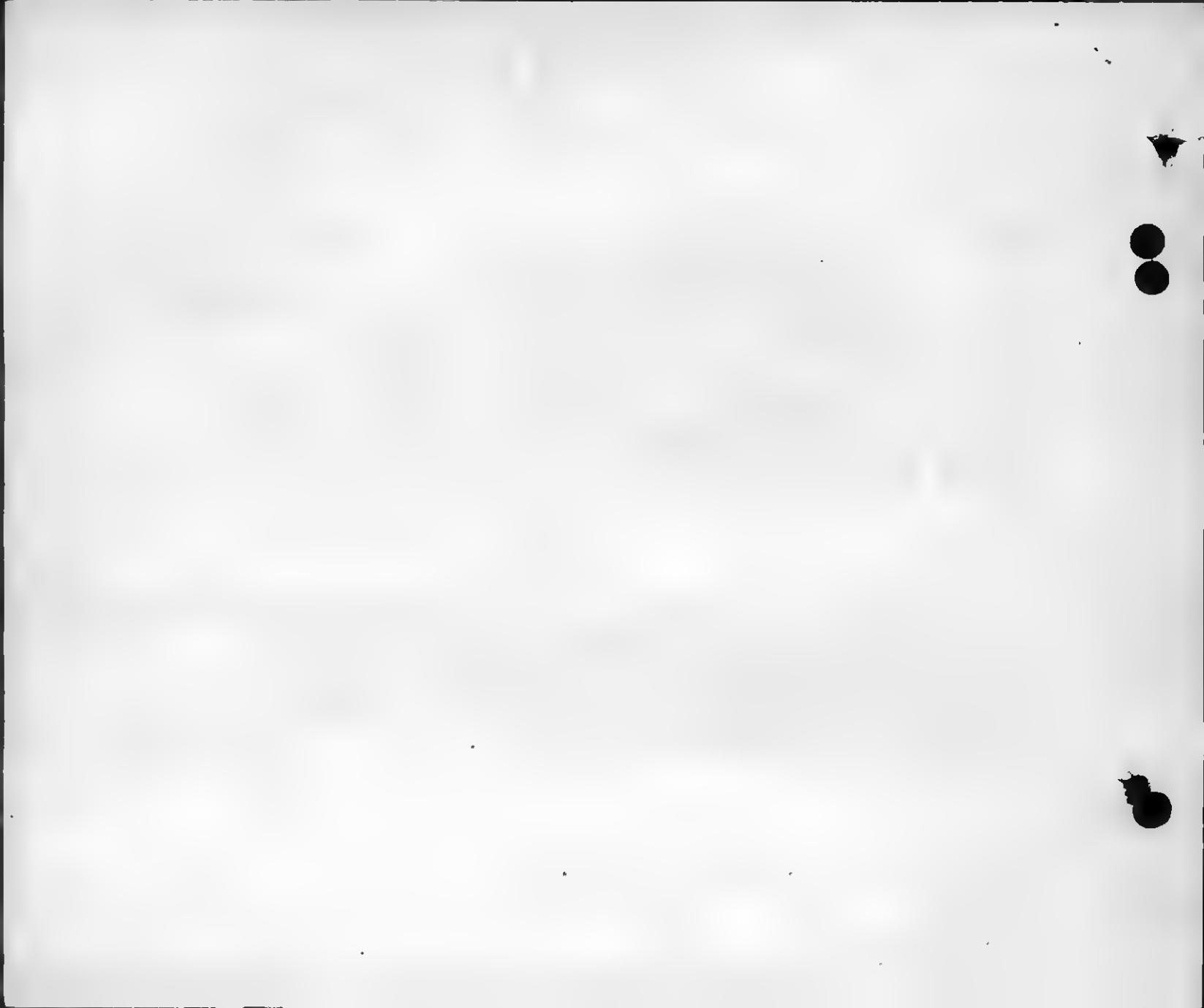
7003

CERTIFICATE OF DEATH

Reg. Dist. No.

06990

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4410 Puller Drive				d. STREET ADDRESS 4410 Puller Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Adelaide Stagemann		First	Middle	Last	4. DATE OF DEATH Month June	Day 2	Year 1961
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 1, 1873	9. AGE (In years last birthday) 87 yrs	IF UNDER 1 YEAR Months 9	IF UNDER 24 HRS Hours 1	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA-Naturalized	
13. FATHER'S NAME John Stagemann		14. MOTHER'S MAIDEN NAME Dorthea VonWerman					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Dorothea Armstrong-Daughter-same 2d		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO Acute Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH 6 hrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO Hypoproteinemia, Anemia Chronic Delitiation		6-8 mo.		2-3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Rheumatoid Arthritis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1959, to June 2, 1961, that I last saw the deceased alive on _____, 1961, and that death occurred at 3:30 P.M. from the causes and on the date stated above ACTUAL SIGNATURE Robert T. Thibadeau MD		ADDRESS (Street, city or town, state) 10609 Concord Street		DATE SIGNED			
PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D.		Kensington, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/5/61		22c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUN 8 '61		24b. REGISTRAR'S SIGNATURE Robert S. Kraus	



TO HOSPITAL or **ATTENDING PHYSICIAN:** The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page VR A15 (4) 15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2004

CERTIFICATE OF DEATH

06091

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 56 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		e. STREET ADDRESS 5 Bayberry Lane	
3. NAME OF DECEASED (Type or print) Thomas Green		f. DATE OF DEATH PEYTON	
4. SEX Male		5. COLOR OR RACE Caucasian	
6. MARRIED WIDOWED		7. NEVER MARRIED DIVORCED	
8. DATE OF BIRTH 1-10-94		9. AGE (In years last birthday) 67 yrs	
10a. JEWISH OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
11. BIRTHPLACE (County & State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Bernard PEYTON		14. MOTHER'S MAIDEN NAME Louise RAMSEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1911 - 1947	
17. INFORMANT (W) Mrs. Mary M. Peyton, same as #2 above		18. ADDRESS INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) Lymphosarcoma, with metastases			
PART I. DEATH WAS CAUSED BY: MADE ATTEMPT (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) DUE TO (c)	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from May 3, 1961 to June 28, 1961 , that (X) (we) last saw the deceased alive on June 28, 1961 , and that death occurred at M , from the causes and on the date stated above.		22b. DATE SIGNED 6-29-61	
22a. SIGNATURE V. L. Kelley		22b. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) B. L. KELLEY, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 7-3-61	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Arlington National		23d. LOCATION (City, town or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey Jr.		25a. REC'D. BY REGISTRAR Arthur S. Kraus	
25b. REGISTRAR'S SIGNATURE DATE JUL 3 '61			

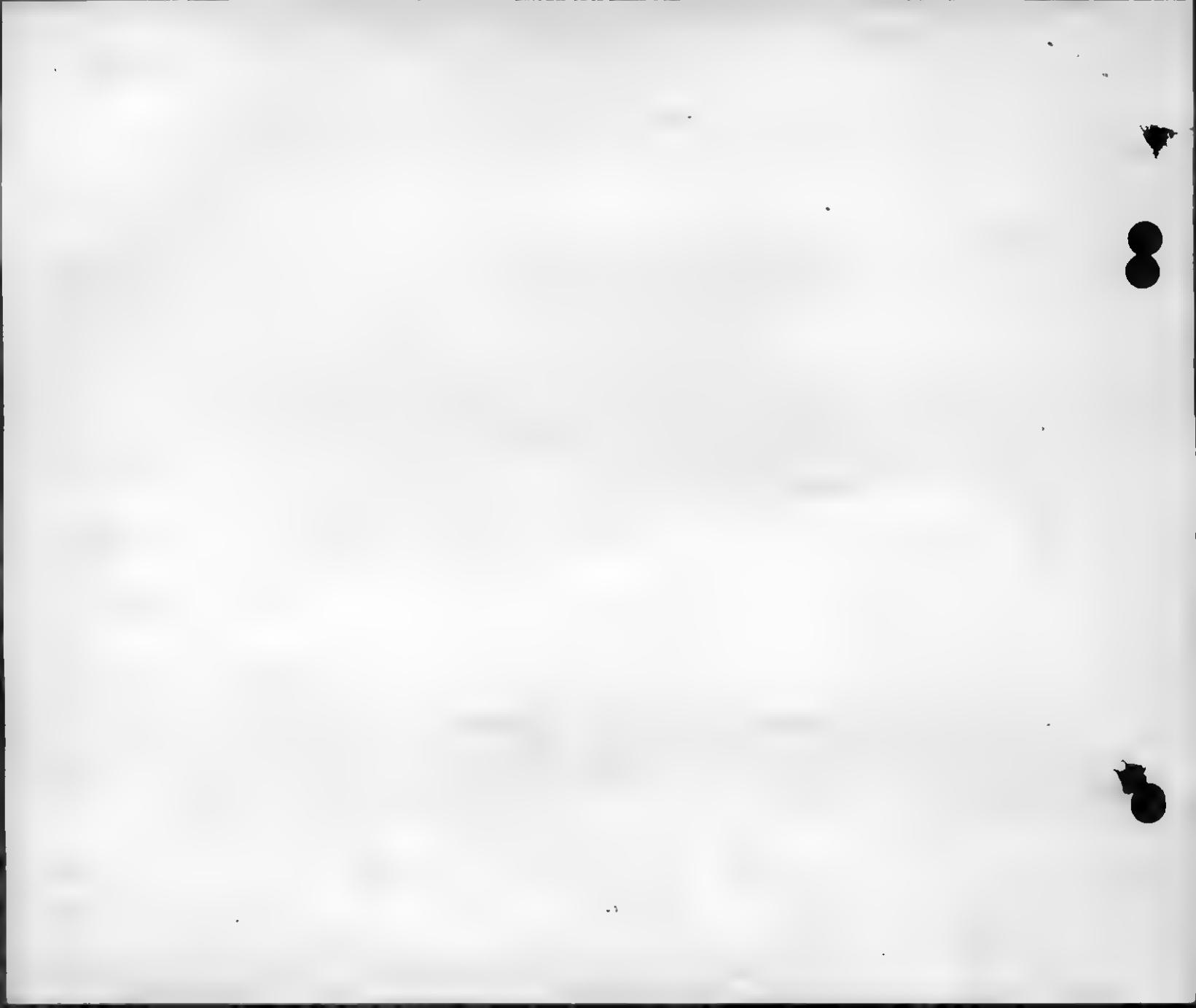


Page 4

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND																							
CERTIFICATE OF DEATH																							
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND						b. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Mont.</i>																	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> 9 days						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase</i>																	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>						d. STREET ADDRESS <i>14124 - Aspen St.</i>																	
						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Floyd J. Porter</i>						4. DATE OF DEATH Month Day Year <i>June 2 1961</i>																	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birthday)		10. IF UNDER 1 YEAR IF UNDER 24 HRS.													
<i>Male</i>		<i>white</i>				<i>9/4/83</i>		77 yrs.		Months <i>8</i>	Days <i>28</i>	Hours	Min.										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY											
<i>Judge</i>				<i>Patent Office N.Y.</i>				<i>Eleanor Anna</i>				<i>U.S.A.</i>											
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME																			
<i>John B. Porter</i>				<i>Blanche H. Porter / Mrs. A bone</i>																			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>												16. SOCIAL SECURITY NO.		17. INFORMANT		Address							
												<i>None</i>		<i>Blanche H. Porter / Mrs. A bone</i>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Generalized Arteriosclerosis</i>												i week.											
(b) <i>Fracture of Neck of Right Femur.</i> DUE TO (c)												10 yrs											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <i>Fall at home - incurred due to Gen. Arteriosclerosis</i>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II or item 18)				20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
<i>House</i>				<i>May 21 1961</i>				<i>Not while of work</i>				<i>House</i>				<i>Chevy Chase Md.</i>							
21. I certify that (1) (this hospital) attended the deceased from <i>June 1 1953</i> to <i>June 2 1961</i> , that (2) (we) last saw the deceased alive on <i>June 1 1961</i> , and that death occurred at <i>14124 - Aspen St.</i> , from the causes and on the date stated above.												22b. DATE SIGNED											
22a. SIGNATURE						M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED											
<i>John R. Ewan</i>												<i>6/2/61</i>											
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS								<i>1835 Eye St. N.W. Washington DC</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORIUM				23d. LOCATION (City, town, or county)				(State)							
<i>Burial</i>				<i>6/6/61</i>				<i>Ft. Lincoln Cemetery</i>				<i>Prince Geo. Co. Maryland</i>											
24. FUNERAL DIRECTOR'S SIGNATURE												25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
<i>Robert A. Pumphrey</i>												ADDRESS				DATE <i>JUN 8 '61</i>				<i>John S. Thom</i>			



1
 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 File G208 6/14/61 1wk

CERTIFICATE OF DEATH

Reg. Dist. No.

66993

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Montgomery		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY	
Sandy Spring	65 yrs	Montgomery	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	1. SANDY SPRING Sandy Spring Rd.		
3. NAME OF DECEASED (Type or print)		First	Middle
MARY		Alice	Powell
4. DATE OF DEATH	Month	Day	Year
JUNE	3	1961	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
F	C	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	July 27, 1896
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
64 6/8 yrs.		Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
housewife		11. BIRTHPLACE (State or foreign country)	
		Maryland, Montg Co. USA	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?	
Richard Hill		SARAH JANE POWELL	
14. MOTHER'S MAIDEN NAME		Address	
SARAH Frances Powell		Sandy Spring	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)			
No			
16. SOCIAL SECURITY NO		INFORMANT	
none		Sarah Frances Powell	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
420.0 DUE TO HEART FAILURE			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO ARTERIOSCLEROTIC HEART DISEASE 8 YEARS			
(c)			
INTERVAL/BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACC. DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from July 19, 1961, to JUNE 1961, that I last saw the deceased alive on MAY 31, 1961, and that death occurred at 9:10 P.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)			
DATE SIGNED JUNE 3, 1961			
ACTUAL SIGNATURE S. Sieben K. Ziegler M.D. JUNE 3, 1961			
PHYSICIAN'S NAME (Type)			
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/6/61	
22c. NAME OF CEMETERY OR CREMATORIAL Ash Memorial,		22d. LOCATION (City, town, or county) Sandy Spring, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snodder		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR DATE JUN 12 '61		24b. REGISTRAR'S SIGNATURE Robert L. Snodder	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be filled in by the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4 should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7007

06994

1. PLACE OF DEATH

a. COUNTY
Montgomeryb. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural)d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
U. S. Naval Hospital

MARYLAND

c. LENGTH OF STAY IN 1b

9~~8~~ days3. NAME OF DECEASED
(Type or print)

First Middle

Paul

Robert

PREPELICA

5. SEX

6. COLOR OR RACE

Male

Caucasian

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

B. DATE OF BIRTH

June 1 1961

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Child

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Montgomery Maryland

USA

13. FATHER'S NAME

William John PREPELICA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURTY NO.
(Yes, no, or unknown) (If yes give war or dates of service)

14. MOTHER'S MAIDEN NAME

Delores Maxine COLBERT

Address

No

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

776X DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last. (b)

DUE TO

(c)

Prematurity

INTERVAL BETWEEN
ONSET AND DEATH
90 DAYS

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)19. WAS AUTOPSY
PERFORMED?
YES NO 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED
p.m. While at work Not While at work
19 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from June 1 1961 to June 10 1961, that (W) (we) last saw the deceased alive on June 10 1961, and that death occurred at ... M, from the causes and on the date stated above.

22a. SIGNATURE

Robert V. RACK LT, MC, USN

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. 22b. DATE SIGNED
6-10-6122c. PHYSICIAN'S NAME (Type)
Robert V. RACK LT, MC, USN
U. S. Naval Hospital, Md.23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial 6-14-61 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS
Arlington National Cemetery Arlington, Virginia
Rockville, Md.

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE
Tyson Wheeler 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
Tyson Wheeler Funeral Home, 1331 Montgomery Ave. JUN 13 '61 Charles S. Kraus

within 24 hours after

death.

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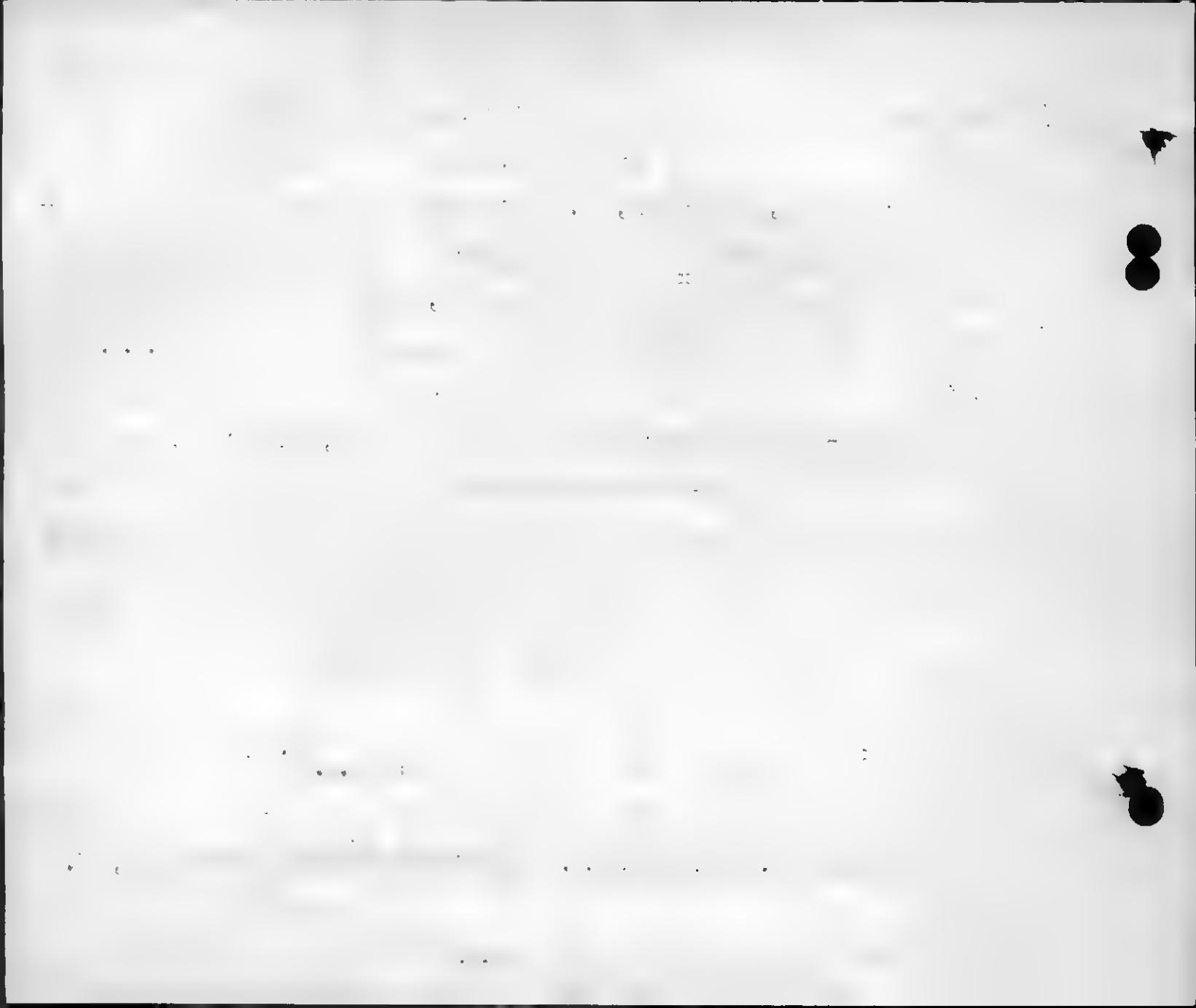
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Page 4

may be reprinted if hospital or attending physician
or FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 64 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE New York b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn d. STREET ADDRESS 2355 East 27th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Stanley		First Stanley	Middle (None)	Last Press	4. DATE OF DEATH June 15 1961	Month June	Day 15	Year 19 61		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 24, 1934		9. AGE (In years last birthday) 27 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman			10b. KIND OF BUSINESS OR INDUSTRY Provision			11. BIRTHPLACE (State or foreign country) New York				
12. CITIZEN OF WHAT COUNTRY? U.S.A.										
13. FATHER'S NAME Philip Press					14. MOTHER'S MAIDEN NAME Bertha Fayer					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>		16. SOCIAL SECURITY NO. 1957-1959		17. INFORMANT The Medical Record Address Unascertainable The Clinical Center, Bethesda 14, Maryland						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH 9 months		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myelogenous Leukemia 204 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Septicemia DUE TO (c)								48 hours		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 12 1961 to June 15 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 15 1961 and that death occurred at 8:30 p.m. from the causes and on the date stated above.										
22a. SIGNATURE- Richard E. Rieselbach		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 6/16/61						
22c. PHYSICIAN'S NAME (Type) RICHARD E. RIESELBACH, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-18-61		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION (City, town, or county) NEW YORK, N.Y.			
24. FUNERAL DIRECTOR'S SIGNATURE BERNARD DANZANSKY & SONS 3501 14th Street, N.W.					ADDRESS		25a. REC'D BY REGISTRAR JUN 19 1961		25b. REGISTRAR'S SIGNATURE C. Danzansky	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7003

CERTIFICATE OF DEATH

C6996

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Germantown (Rural)

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Marylander Nursing Home

3. NAME OF DECEASED
(Type or print)

First

Middle

Margaret Elizabeth Ragan

4. SEX

White

Female

WIDOWED

DIVORCED

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Dec. 7, 1879

4. DATE OF DEATH

Month Day Year

June

18

19 61

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Housewife

Washington, D. C.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Dennis McCarthy

Mary O'Brien

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

No

Joseph B. Ragan - son - same 2d

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Bobav Pneumonia, Bilateral

423.0

DUE TO

Conditions, any, which
give rise to immediate cause
(a), stating the underlying
cause first

(b)

Pulmonary Edema, Congestive Heart Failure

DUE TO

(c)

Arteriosclerotic Hypertensive Heart Disease

INTERVAL BETWEEN
ONSET AND DEATH

6 days

11 days

2 years

MEDICAL CERTIFICATION

Left Hemiplegia

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

19. WAS AUTOPSY
PERFORMED?
 YES NO

20c. TIME OF INJURY
Hour a.m.
p.m.

Month, Day, Year
While at work Not While at work

20d. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20e. (City or town)

(County)

(State)

19 61

20f. (City or town)

20g. (County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 6 June 1961 to 18 June 1961, that (I) (we) last saw the deceased alive on 7 June 1961, and that death occurred at 9 A.M. from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

Gordon M. Smith

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22d. ADDRESS

22b. DATE
SIGNED

6/18/61

Dawsonville, Maryland

23a. BURIAL, CREMATION, DATE THEREOF
REMOVAL (Specify)

23c. NAME OF CEMETERY OR CREMATORIAL

23d. LOCATION (City, town or county)

(State)

Burial 6/21/61

Mt. Olivet Cemetery

Washington, D. C.

ADDRESS

Bethesda, Maryland

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

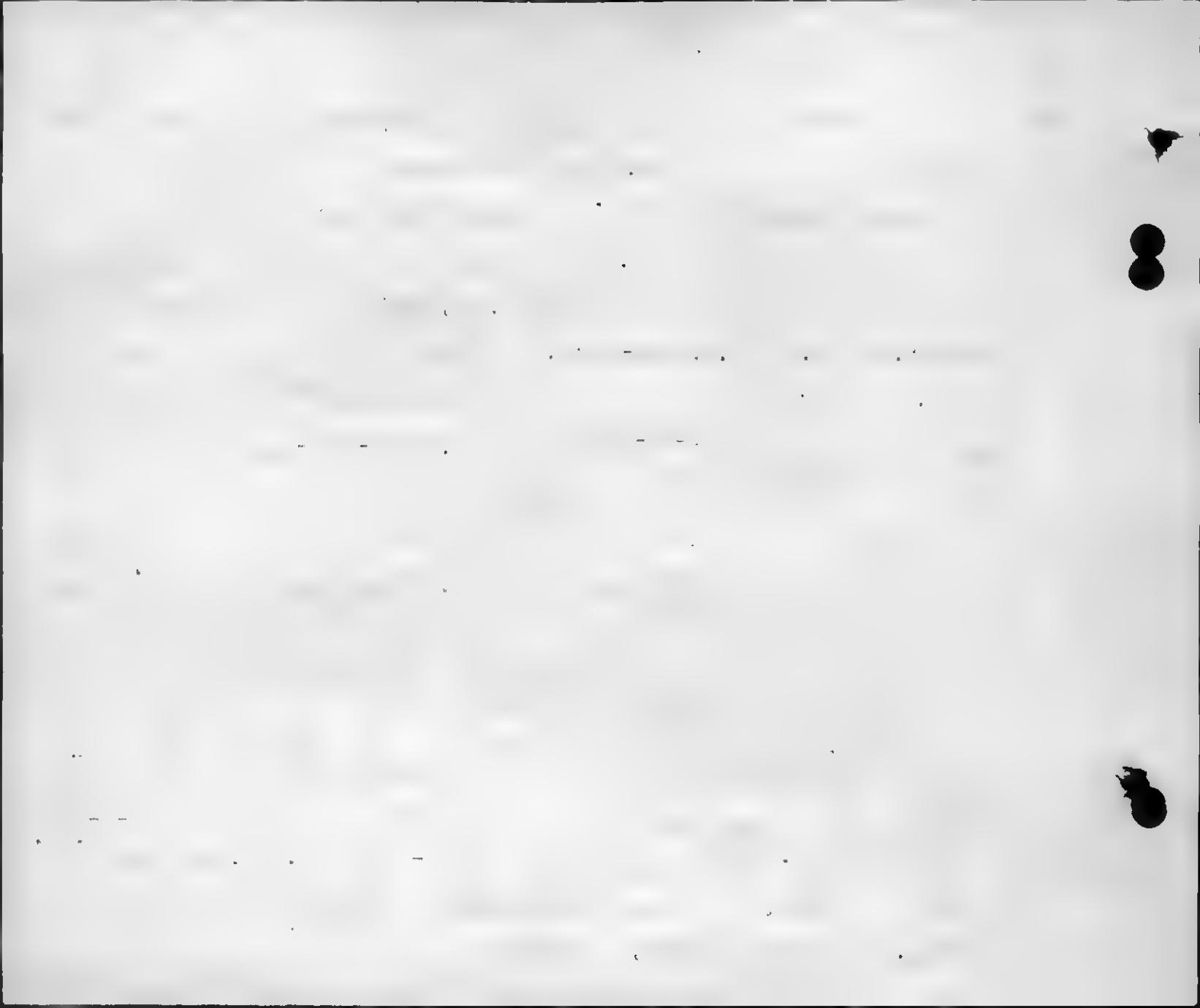
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

C6997

7010

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
Montgomery		b. STATE	
		Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
Kensington		Montgomery	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
1 mo. 5 days		Kensington	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3000 Mc Comas Ave.		10608 Nash Place	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
FREDERICK		V.	RAND
4. DATE OF DEATH		Month	Year
June 6, 1961		Day	Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min.	
Mch. 16, 1883		78 yrs. 2 20 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Plant Bact. & Path.		U. S. Govt-Agric.	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Vermont		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Rev. Wilbur Rand		Mary Jane Miller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO		17. INFORMANT	
(Yes, no, or unknown) (If yes give war record and date of service)		Address	
No		263-46-4843A Louva H. Rand-wife-Same as Item #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		21 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b)		7 years	
DUE TO		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
DUE TO		20. MEDICAL CERTIFICATION	
DUE TO			
21. I certify that (I) (this hospital) attended the deceased from <u>May 1, 1961</u> , to <u>June 6, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 6, 1961</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE		22b. DATE SIGNED	
<u>Neil P. Campbell</u>		6-6-61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
NEIL P. CAMPBELL		3060 - 16th St., N. W., Washington	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Cremation		6/7/61	
23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county) (State)	
Cedar Hill Crematory		Prince Georges Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR	
Robert A. Pumphrey Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE	
		Arthur S. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after the deceased died in the hospital or attending physician may be retained. This certificate has been signed by the attending physician and completely filled in by the funeral director. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

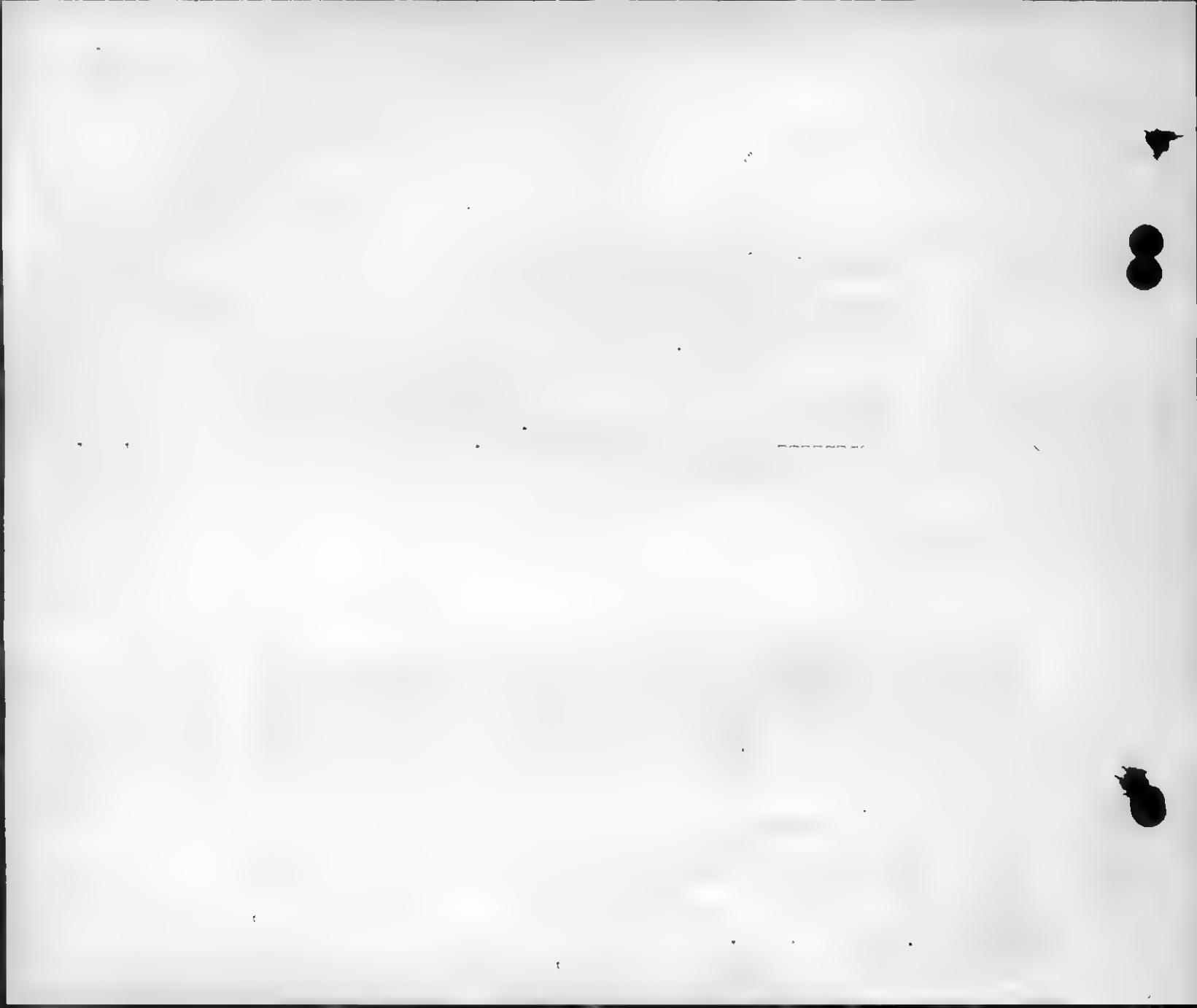
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

66998

7011

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fairland</i>		b. COUNTY <i>Montgomery</i>	
c. LENGTH OF STAY IN 1b <i>1 month</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Fairland Nursing Home</i>		d. STREET ADDRESS <i>316 Ladson Road</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>ROBERT BLANCHE HANNAH RANDALL</i>	First <i>R</i>	Middle <i>B</i>	Last <i>HANNAH RANDALL</i>
4. DATE OF DEATH <i>6 15 1961</i>	Month <i>6</i>	Day <i>15</i>	Year <i>1961</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/9/81</i>
9. AGE (In years last birthday) <i>80 yrs.</i>	10. US-JAF OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>	12. BIRTHPLACE (State or Foreign country) <i>M.D.</i>
13. CITIZEN OF WHAT COUNTRY? <i>USA</i>	14. MOTHER'S MAIDEN NAME <i>ELIZABETH GUTHRIE GRAHAM</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO <i>NONE</i>	17. INFORMANT <i>Mrs. Margie Marie Randall</i>	Address <i>110 St. Lawrence Drive Silver Spring, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARCINOMATOSIS</i> DUE TO <i>153-X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) <i>CARCINOMA OF COLON</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>1-2 MONTHS</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>1934 to June 15, 1961</i> , that (I) (we) last saw the deceased alive on <i>June 12, 1961</i> , and that death occurred at <i>11 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Robert B. Irey</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>6-15-61</i>
22c. PHYSICIAN'S NAME (Type) <i>ROBERT B. IREY</i>		22d. ADDRESS <i>7105 Riggs Rd. Hyattsville, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>6/19/61</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Parklawn Cemetery</i>	23d. LOCATION (City, town, or county) <i>Montgomery, Maryland</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Warner L. Pumphrey, Inc.</i>	ADDRESS <i>8434 Georgia Avenue</i>	25a. REC'D BY REGISTRAR <i>JUN 20 '61</i>	25b. REGISTRAR'S SIGNATURE <i>Robert S. Kline</i>
Raymond A. WILSON			



FOR STATE
HEALTH DEPT.

delay is necessary,
please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form M3. Page 5 may be retained for your files.

M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66999

1. PLACE OF DEATH
a. COUNTY

Montgomery
Silver Spring

MARYLAND

c. LENGTH OF STAY IN 16

6 yrs

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)

a. STATE

MD

b. COUNTY

Monty

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

d. STREET ADDRESS

1800 Hollywood Ave

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
(Type or print)

Kenneth Donald Rankin

First

Middle

Last

4. DATE
OF
DEATH

June 22 1961

Day

Month

Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Clerk (Mail)

10b. KIND OF BUSINESS OR INDUSTRY

DC Post office

11. BIRTHPLACE (State or foreign country)

R. I.

12. CITIZEN OF WHAT COUNTRY?

M. S. A.

13. FATHER'S NAME

Bright Rankin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give rank, dates of service)

No

16. SOCIAL SECURITY NO

117-07-1502

17. INFORMANT

Clara Rankin (wife)

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Coronary occlusion

720.1 DUE TO

Conditions, if any, which

gave rise to immediate cause

(a), stating the underlying

cause last.

{ (b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, e.g.

20a. EXTERNAL CAUSE WAS

PRIMARY or CONTRIBUTING

CAUSE OF DEATH.

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED

While at work

Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion

death resulted from Natural causes Accident , Suicide , Homicide , Undetermined manner

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

22e. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

BURIAL JUNE 24, 1961

MAYFLOWER HILL CEMETERY

ADDRESS

SILVER SPRING, MD.

TAUNTON, MASSACHUSETTS

23. FUNERAL DIRECTOR

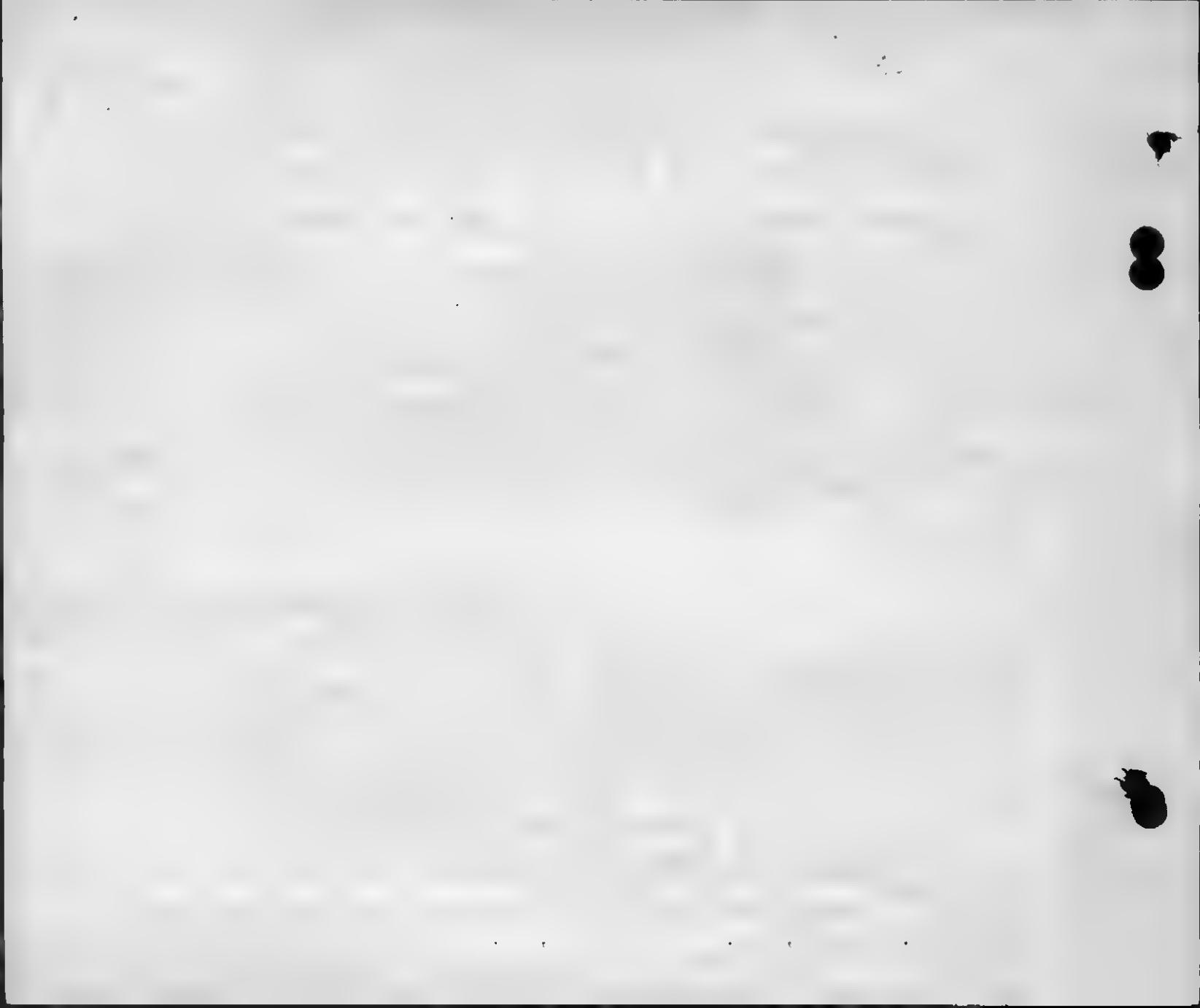
WALTER E. PUMPHREY, INC.

Raymond A. Zaleski

24e. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

INTL S. KRAUS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Hospital or attending physician, if either, may be responsible.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7013 07000

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived - If institution Residence before admission) a. STATE <i>D.C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>9 yrs 11 mo</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Alta Vista Nursing Home</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>	
3. NAME OF DECEASED (Type or print) <i>Bartha</i>		d. STREET ADDRESS <i>4930 Butterworth Pl. S.W.</i>	
4. SEX <i>F</i>	5. COLOR OR RACE <i>W</i>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>Feb. 14, 1869</i>
8. AGE (In years lost birthday) <i>92 yrs.</i>		9. IF UNDER 1 YEAR Months <i>7</i> Days <i>14</i>	10. IF UNDER 24 HRS Hours <i>2</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>N/A</i>	
11. BIRTHPLACE (State or foreign country) <i>N.Y.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>George Deager</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Frederick</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mrs Lydia Mosley</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) (c) DUE TO Cerebral Hemorrhage	
		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <i>Cerebral Arteriosclerosis</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 17 to June 15, 1961, that (I) (we) last saw the deceased alive on May 30, 1961, and that death occurred at 3:20 P.M. from the causes and on the date stated above.		20f. (City or town) (County) (State)	
22a. SIGNATURE <i>Robert B. Havell</i>		22b. DATE SIGNED <i>June 15, 1961</i>	
22c. PHYSICIAN'S NAME (Type) <i>Robert B. Havell, M.D.</i>		22d. ADDRESS <i>5516 N. 16th Ave., DC</i>	
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6/17/61</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Cemetery</i>		23d. LOCATION (City, town, or county) <i>Princedale Georges County, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>The A.H. Fine Co. 2801-15 St. N.W. DC</i>		25a. REC'D BY REGISTRAR ADDRESS <i>44 St. N.W. DC</i> DATE JUN 20 '61	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Fine</i>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician, or retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7014

CERTIFICATE OF DEATH

07001

1. PLACE OF DEATH
a. COUNTY
Montgomery
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)
Bethesda (Rural)
c. LENGTH OF STAY IN IB

MARYLAND

29 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
U. S. Naval Hospital

3. NAME OF DECEASED
(Type or print)
Robert

First

Middle

Oscar

4. SEX
Male

6. COLOR OR RACE
Caucasian

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE
Virginia

b. COUNTY
Alexandria

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Alexandria

d. STREET ADDRESS

3904 Cavendish Drive

Last

Month

Day

Year

4. DATE OF DEATH
June 14 1961

9. AGE (In years last birthday) IF UNDER 1 YEAR
35 yrs. Months Days Hours Min.

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Officer

10b. KIND OF BUSINESS OR INDUSTRY
U. S. Marine Corps

11. BIRTHPLACE (County & State, or foreign country)
Texas

12. CITIZEN OF WHAT COUNTRY?
USA

13. FATHER'S NAME
William O. RISINGER

14. MOTHER'S MAIDEN NAME
Mary Eula NICHOLS

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO., 17. INFORMANT
(Yes, no, or unknown) (If yes, give rank or date of service)
Yes **1942-1961** **463-26-0848 (W)** Mrs. Ann C. RISINGER, same as #2 above

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

154X DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause (b),

(b)

DUE TO

(c)

*Caused by a heart attack
which was due to hypertension*

INTERVAL BETWEEN
ONSET AND DEATH

7 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

Hour
e.m.
p.m.

Month
19

Day

Year

While
at work

Not While
at work

at work

20f. (City or town)

(County)

(State)

21. I certify that (this hospital) attended the deceased from **May 16**, 1961, to **June 14**, 1961, that (we) last saw the deceased alive on **June 14**, 1961, and that death occurred at **6 P.M.** from the causes and on the date stated above.

22e. SIGNATURE
Larry J. Hines

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

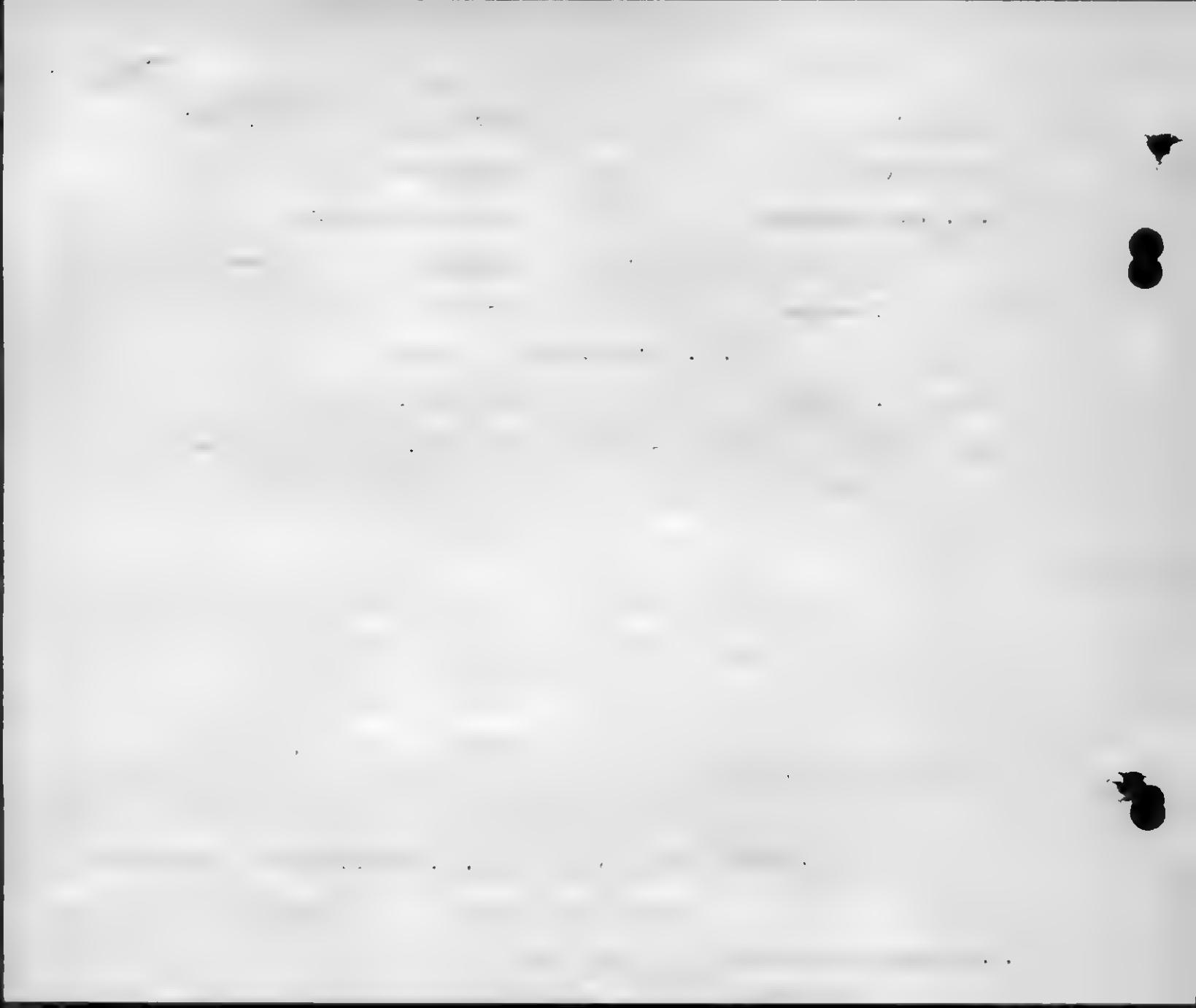
22d. ADDRESS

22b. DATE SIGNED
6-15-61

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS

23d. LOCATION (City, town or county) (State)
Arlington **Virginia**

24 FUNERAL DIRECTOR'S SIGNATURE *W.W. Chambers Co.* 25a. REC'D BY REGISTRAR JUN 19 1961 25b. REGISTRAR'S SIGNATURE
W.W. Chambers Co., 1400 Chapin St., NW, Wash DC DATE *Arthur S. Kraus*



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07002

7015

1. PLACE OF DEATH
a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda

MARYLAND
c. LENGTH OF STAY IN 1B

31 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Suburban Hospital

First

Middle

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rockville

d. STREET ADDRESS

213 Ritchie Parkway

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

June

1961

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

May 2 1879

9. AGE (in years
last birthday)

82 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10b. KIND OF BUSINESS OR INDUSTRY

Cook

11. BIRTHPLACE (County & State, or foreign country)

Turin, Italy

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

12. CITIZEN OF WHAT COUNTRY?

Italy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give rank or date of service

No

16. SOCIAL SECURITY NO.

578-05-1976

17. INFORMANT

ARNOLD Roccati (son)

Address

Same as above.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

441X

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

CONFIDENT DROWNS IN MUNICIPAL

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). 19. WAS AUTOPSY
PERFORMED?

YES NO

20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 1960, to 1 June, 1961, that (I) (we) last
saw the deceased alive on 31 May 1961, and that death occurred at 1 PM, from the causes and on the date stated above.

22e. SIGNATURE

John G. Ball

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED

22d. ADDRESS

7936 Old Georgetown Rd., Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

6/5/61

23c. NAME OF CEMETERY OR CREMATORIUM

St. Marys

23d. LOCATION (City, town or county)

Rockville, Maryland

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

Tyson Wheeler Funeral Home, 1331 E. Montg. Ave.
Rockville, Md.

ADDRESS

25a. REC'D. BY REGISTRAR

JUN 5

61

25b. REGISTRAR'S SIGNATURE

John S. Smith

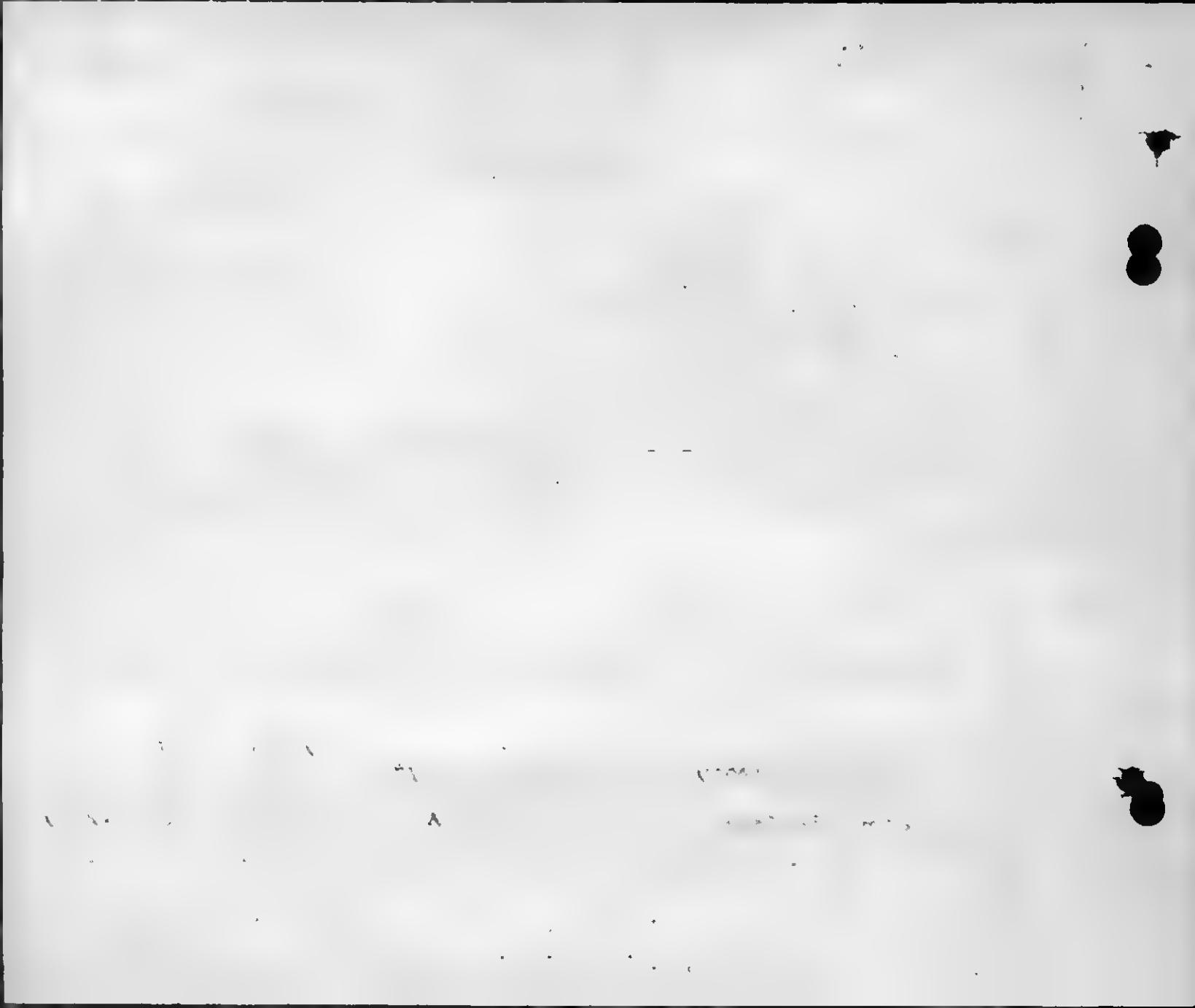
DATE

2

M

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2



X 1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C7003

1. PLACE OF DEATH

a. COUNTY

Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Takoma Park

MARYLAND

c. LENGTH OF STAY IN 1b

2 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington Sanitarium and Hospital

3. NAME OF

First

Middle

Last

(Type or print)

Norman

N.M.N.

Rosner

5. SEX

6. COLOR OR RACE

Male

white

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Salesman

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Real Estate

New York

13. FATHER'S NAME

I Morris Rosner (DEC)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO.

(If yes, give rank, dates of service)

Yes WW2 Army 055-10-7740

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

DUE TO

Brain stem compression

Cerebral laceration + hemorrhage

Bullet wound thru rt temple

INTERVAL BETWEEN
ONSET AND DEATH

1 1/2 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.a)

19. WAS AUTOPSY PERFORMED?

YES NO 20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20c. TIME OF INJURY Month, Day, Year

Hour 2:30 p.m.

6-9 1961

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

Self inflicted bullet wound thru rt temple

20c. INJURY OCCURRED While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

Home Silver Spring Montg Md

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opiniondeath resulted from: Natural causes Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER

ACTUAL SIGNATURE Frank J. Broschart

EXAMINER'S NAME (Type) Frank J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF 6/14/61

22c. NAME OF CEMETERY OR CREMATORIUM ARL. NATL. CEM. ARL. VA.

23. FUNERAL DIRECTOR Goldberg & Son

ADDRESS 4217 E. 26th St.

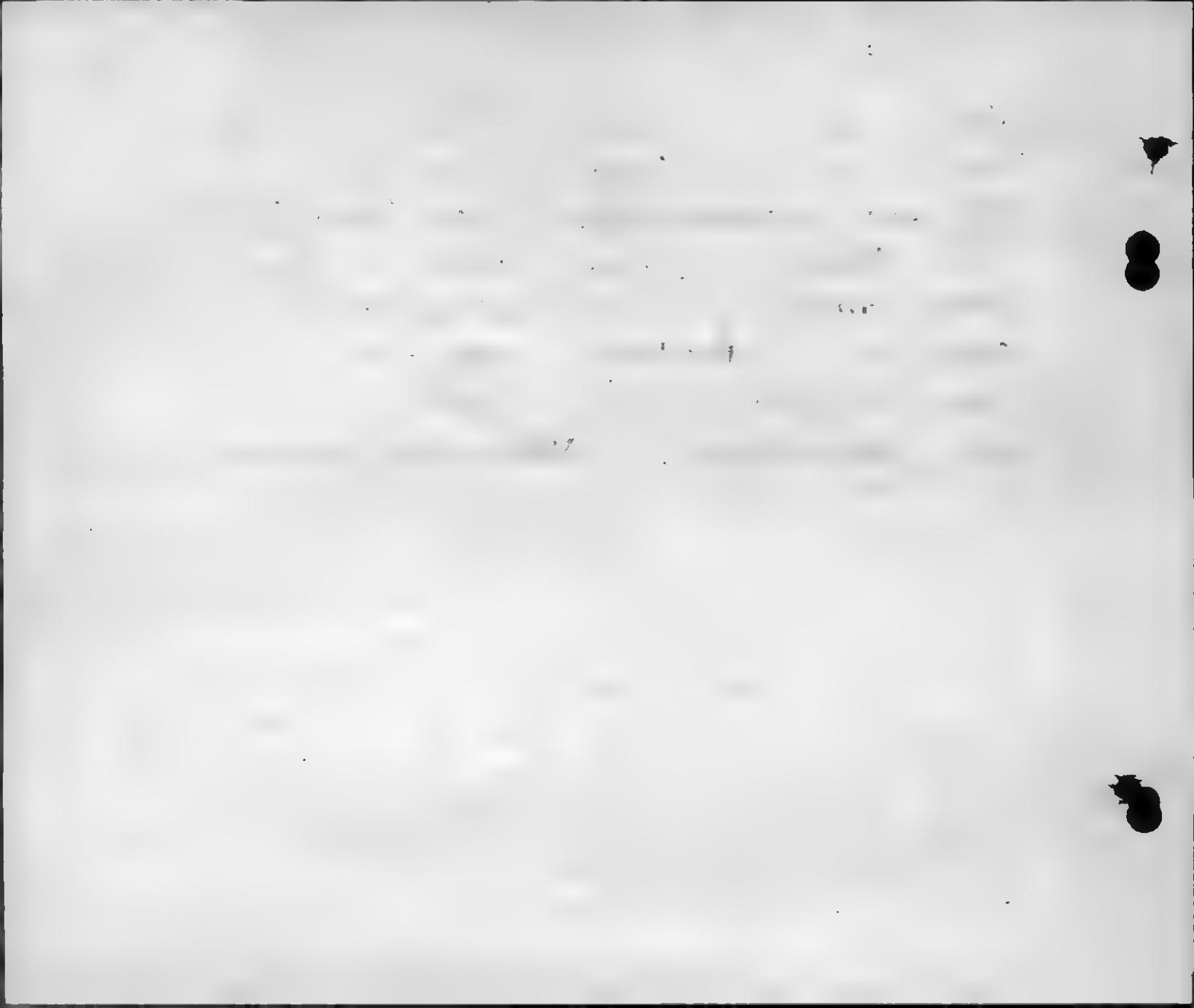
24a. REC'D BY REG STRR JUN 13 '61

DATE

24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO DEPUTY
Please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9,60



TO HOSPITAL ATTENDING PHYSICIAN: This law requires that this death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07004

7017			
1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		b. COUNTY Montgomery	
c. LENGTH OF STAY IN lb 5½ hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 1550 East West Highway	
3. NAME OF DECEASED (Type or print) John Gray		4. DATE OF DEATH Last Month Day Year June 29 1961	
5. SEX Male Caucasian		6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 11-21-07	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
11. BIRTHPLACE (County & State, or foreign country) California		9. AGE (in years last birthday) IF UNDER 1 YEAR Months Days Hours Min. 53 yrs.	
13. FATHER'S NAME Phillip H. ROWE		14. MOTHER'S MAIDEN NAME Frances J. SIMMONS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 17. INFORMANT 224-52-8212 (Wife) Mrs. Anna Mae Rowe, same as #2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c) } DUE TO		Address <i>Infection myocardium</i> <i>Arteriosclerotic cardiovascular disease</i> 5 1/2 hrs.	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 29, 1961 to June 29, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 29, 1961 , and that death occurred at M. from the causes and on the date stated above.		22b. DATE SIGNED 6-30-61	
22e. SIGNATURE <i>Frances Mae, Jr. Ad</i>		22b. DATE SIGNED 6-30-61	
22c. PHYSICIAN'S NAME (Type) Russell MILLER, JR., LT, MC, USN U. S. Naval Hospital, Bethesda, Md.		22d. ADDRESS	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-3-61	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Arlington National		23d. LOCATION (City, town or county) (State) Arlington Virginia	
24 FUNERAL DIRECTOR'S SIGNATURE S.H.Hines Funeral Home, 2901 14th St., NW, WashDC		25a. REC'D BY REGISTRAR DATE 3 '61	
		25b. REGISTRAR'S SIGNATURE <i>Caribou S. Johnson</i>	

2

WMA

TO HOSPITAL OR HOSPITAL **TO ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 72 hours after death by a physician or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

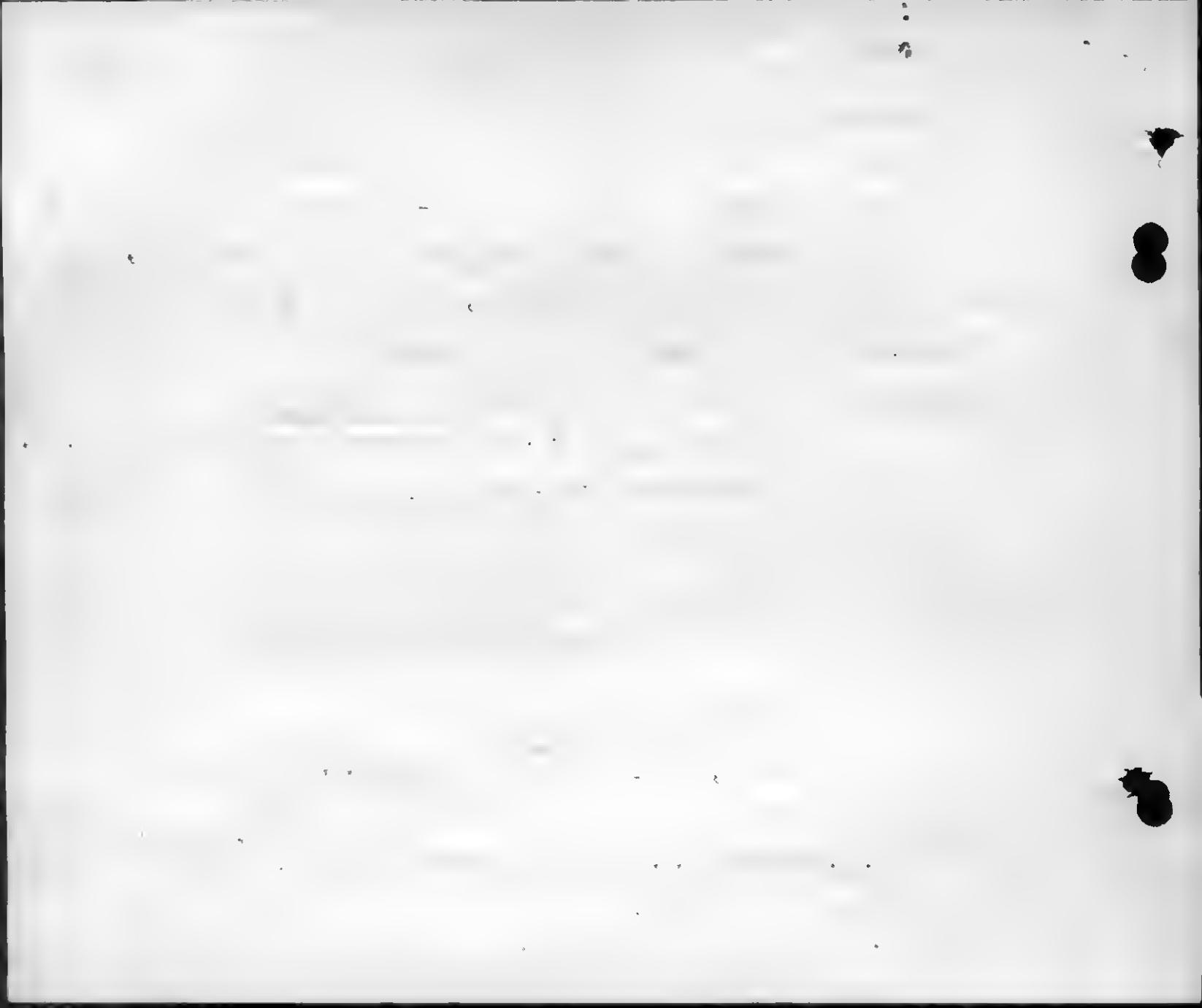
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 9 Form G288 6/1/61 rev. 1

07005

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 86 Days		2. USUAL RESIDENCE (Where deceased lived - If institution Residence before admission) a. STATE New York		b. COUNTY		
3. NAME OF DECEASED (Type or print)		First Julia	Middle Rose	Last Ruggieri	4. DATE OF DEATH June 1, 1961	Month June	Day 1	Year 1961		
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1900	9. AGE (In years, last birthday) 61 60 yrs.	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS Days 60	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Carmelo Marotta				14. MOTHER'S MAIDEN NAME Angelina Ruggieri						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address National Institutes of Health, Bethesda 14, Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 205X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Mycosis Fungoides; with Congestive Heart Failure		DUE TO (b)		DUE TO (c)		5 years 3 days				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Long Island		(County) New York		(State)
21. I certify that (I) (this hospital) attended the deceased from March 7, 1961 , to June 1, 1961 , that (I) (we) last saw the deceased alive on June 1, 1961 and that death occurred at 2:55 P.M. from the causes and on the date stated above.										
22a. SIGNATURE R. B. SCOGGINS, M.D.		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 6/2/61				
22c. PHYSICIAN'S NAME (Type) R. B. SCOGGINS, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 6-2-61		23b. DATE THEREOF 6-2-61		23c. NAME OF CEMETERY OR CREMATORIUM Calvary Cemetery		23d. LOCATION (City, town, or county) Long Island		(State) New York		
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR DATE JUN 8 '61		25b. REGISTRAR'S SIGNATURE Robert A. Pumphrey				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, with 72 hours after death.

VR A15 (4)
ISM 9/59

Dr. John Bell notched and galvanized queen falling sign he M

Page 4
1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived — If institution: Residence before admission) b. STATE New York		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elmhurst							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2 weeks		d. STREET ADDRESS 51-15 Van Kleeck Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Therese		First	Middle	Last	4 DATE OF DEATH June 9 1961	Month	Day	Year					
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-14-1899	9 AGE (In years at last birth) 61 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hat Designer	11. KIND OF BUSINESS OR INDUSTRY Austria	12. CITIZEN OF WHAT COUNTRY? Naturalized					
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Beatrice		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO Landau	17. INFORMANT Husband Tibor T. Schanzer	Address Same as Item #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. INTERVAL BETWEEN ONSET AND DEATH 1 year		PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 153.9		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Cancer, intestinal							
				DUE TO (b)		Post-labor diagnosis unknown to me Empyema and septicemia							
				DUE TO (c)		I had been physician until 5/29/61.							
20a. MEDICAL CERTIFICATION		20b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) May 28 1961, to June 5 1961		20f. (City or town) Bethesda		(County) Montgomery	(State) Maryland
21. I certify that (I) (this hospital) attended the deceased from May 28 1961, to June 5 1961 , that (I) (we) last saw the deceased alive on 6/5 1961 , and that death occurred at 11:30 PM , from the causes and on the date stated above		22a. SIGNATURE Allen J. O'Neill		22b. DATE SIGNED 22d. ADDRESS 8601 Old Georgetown Rd, Bethesda									
22c. PHYSICIAN'S NAME (Type) Allen J. O'Neill MD		22d. ADDRESS 8601 Old Georgetown Rd, Bethesda		23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 6/12/1961		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Crematory		23d. LOCATION (City, town, or county) Prince Georges Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Rumphrey		ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR JUN 12 '61		25b. REGISTRAR'S SIGNATURE James L. Trahan							



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

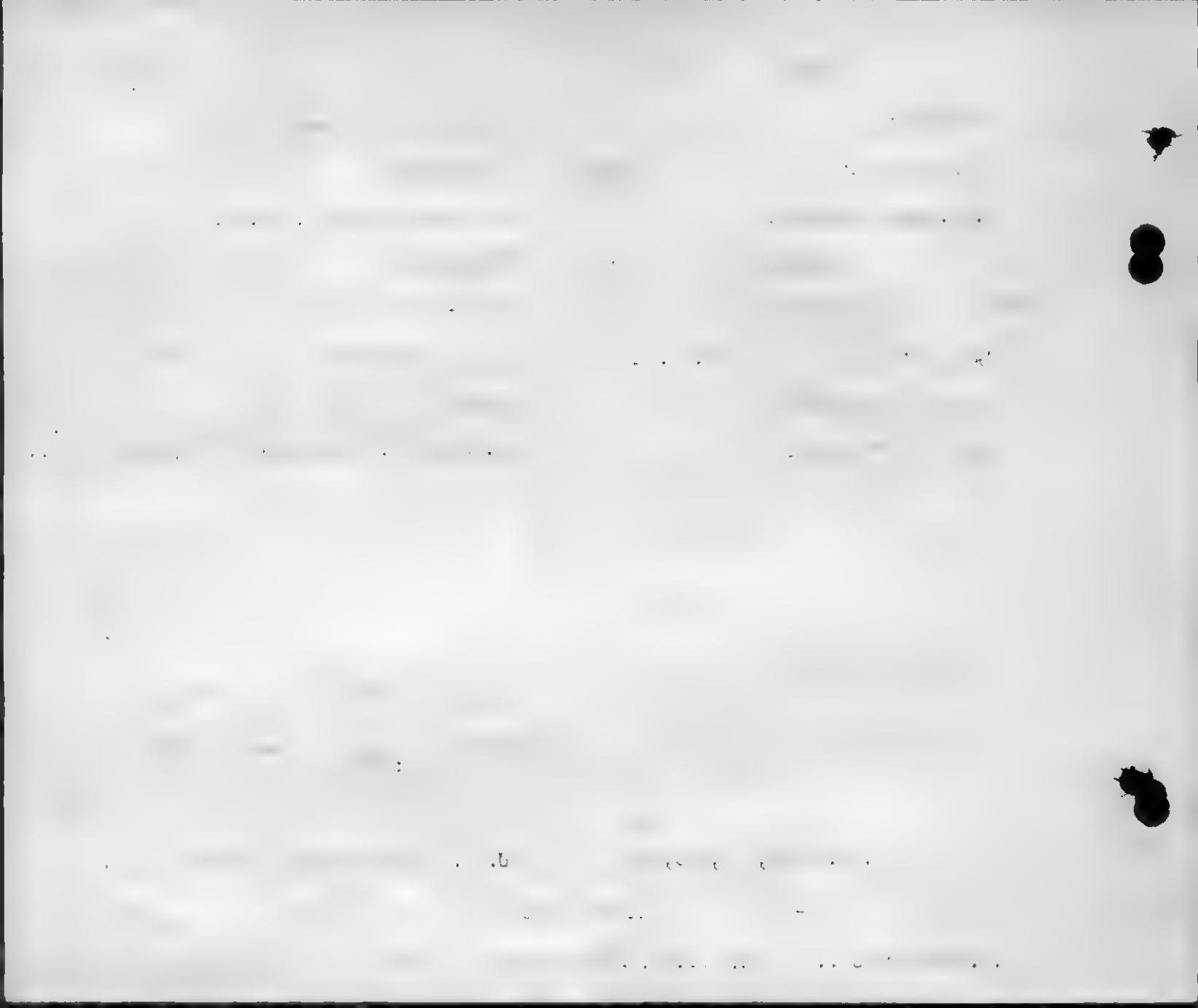
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7020

07007

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		b. COUNTY	
c. LENGTH OF STAY IN lb 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 1715 Kilbourne St., N. W.	
e. FIRST MIDDLE INITIAL Charles Henry		4. DATE OF DEATH Last Month Day Year 12-18-92	
3. NAME OF DECEASED (Type or print) Male		5. SEX b. DATE OF BIRTH 68 yrs.	
6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W.DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (G ve kind of work done during most of working life, even if retired) Armed Forces		10b. KIND OF BUSINESS OR INDUSTRY U. S. Marine Corps	
11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME (unknown) SCHMACKEL		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. WVI & II	
17. INFORMANT (D) Mrs. Clara E. Robertson, 3842 Wyandotte St., Kansas City, Mo.		Address INTERVAL BETWEEN ONSET AND DEATH 3 wks	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hepatic Coma</i> <i>Cirrhosis, Laennec's</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 26, 1961 to June 6, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 6, 1961 , and that death occurred at 10:20PM from the causes and on the date stated above.		22b. DATE SIGNED 6-7-61	
22a. SIGNATURE <i>R. G. Muth</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) R. G. MUTH, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-9-61	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Arlington National		23d. LOCATION (City, town or county) (State) Arlington	
24 FUNERAL DIRECTOR'S SIGNATURE <i>Baker</i>		25a. REC'D BY REGISTRAR W.W. Chambers Co., 3072 M St., NW, Washington, DC	
		25b. REGISTRAR'S SIGNATURE JUN 9 '61	



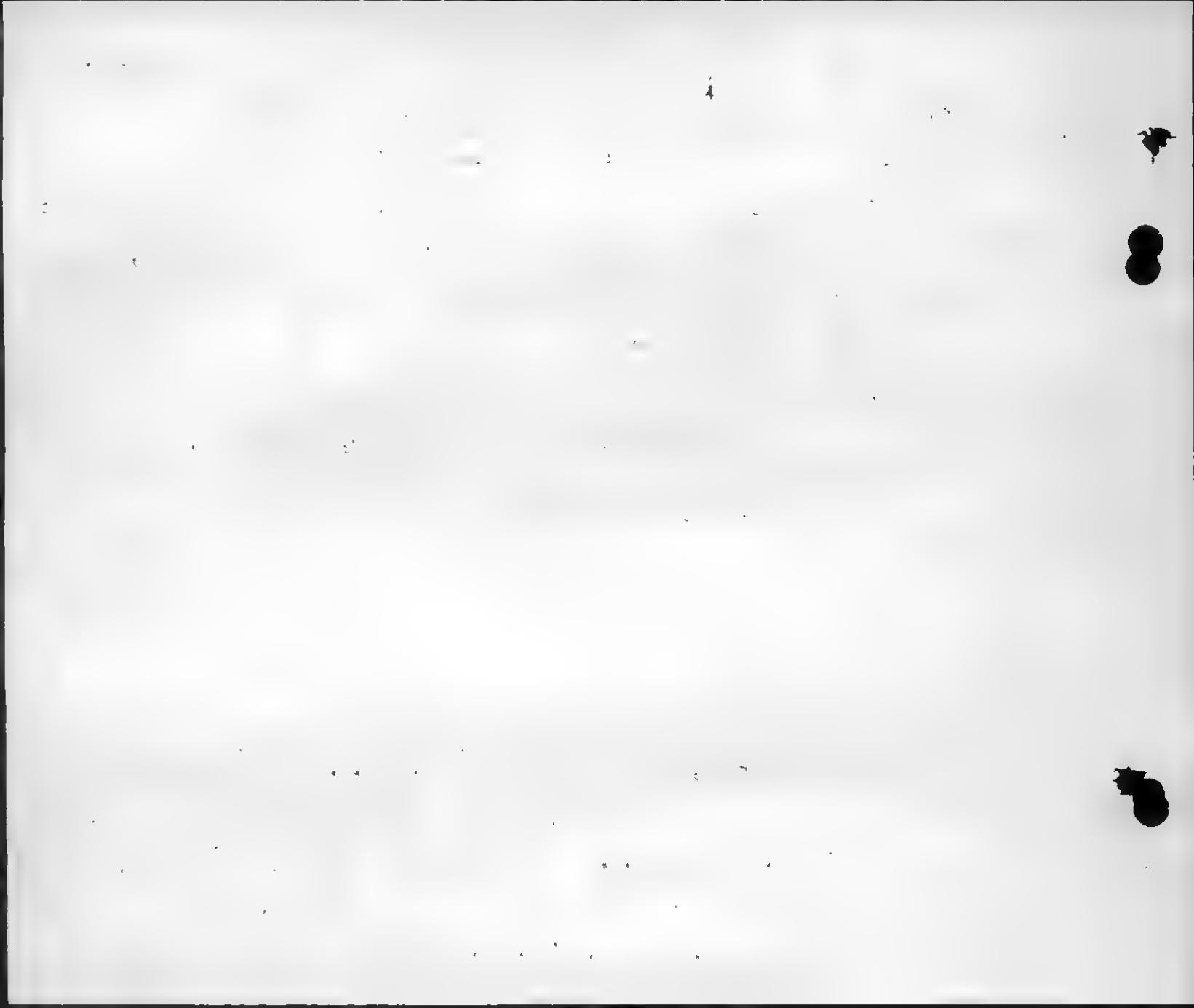
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7021

02008

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 21 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria		d. STREET ADDRESS Route #5, Box 432	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First DOROTHY	Middle ANN	Last SCHMITT	4. DATE OF DEATH	Month June	Day 19,	Year 1961
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 7, 1925	9. AGE (In years last birthday) 36 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. US AL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographer		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Dawson				14. MOTHER'S MAIDEN NAME Victoria Cawman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO Not available		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Uterine Tumor, indifferentiated, Metastatic to lungs, mouth, brain					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 235X		(b)		INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS			
		DUE TO					
		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from May 29, 1961, to June 19, 1961, that (I) (we) last saw the deceased alive on June 19, 1961, and that death occurred at 8:30 a.m. from the causes and on the date stated above.							
22a. SIGNATURE <i>Haskins K. Kashima</i> , M.D.		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 6/19/61			
22c. PHYSICIAN'S NAME (Type) HASKINS K. KASHIMA, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland					
23a. FUNERAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 22 June 61		23c. NAME OF CEMETERY OR CREMATORIAL Arlington National		23d. LOCATION (City, town, or county) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Cunningham</i>		ADDRESS Maymont Cunningham Funeral Home Inc. Box 65, Alex., Va.		25a. REC'D BY REGISTRAR DATE JUN 22 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



TO HOSPITAL OR HOSPITAL DIRECTOR: The law requires that the death certificate be executed within 72 hours after death.

TO ATTENDING PHYSICIAN: The attending physician and completely filled in by the funeral director, has been signed by the attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission)	
<i>Montgomery</i>		a. STATE <i>Va</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olney Rural</i>		b. COUNTY <i>Arlington</i>	
c. LENGTH OF STAY IN TB <i>3 yr 10 mo</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arlington</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Foundation</i>		d. STREET ADDRESS <i>4731 91 34th St</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Laura Mayer Schuyler</i>		4. DATE OF DEATH <i>June 5 1961</i>	Month Day Year 5 1961
5. SEX <i>female</i>		6. COLOR OR RACE <i>Cauc.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Aug 2 1871</i>		9. AGE (In years lost birthday) <i>89 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Pao</i>	
11. BIRTHPLACE (State or foreign country) <i>Pao</i>		12. CITIZEN OF WHAT COUNTRY? <i>415</i>	
13. FATHER'S NAME <i>John Mayer</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Landis</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>NONE</i>	
17. INFORMANT <i>Mrs Cook</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Anterior sclerotic cardiovascular disease	
19. INTERVAL BETWEEN ONSET AND DEATH		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____, from the causes and on the date stated above.		22a. SIGNATURE <i>Laura Mayer Schuyler</i>	
22c. PHYSICIAN'S NAME (Type) <i>JOHN MARTIN</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>6/5/61</i>
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE THEREOF <i>June 5, 1961</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Charles Evans</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Francis X. Barber Laytonsville Md</i>		ADDRESS	25a. REC'D BY REGISTRAR <i>Reading</i>
		DATE JUN 8 '61	25b. REGISTRAR'S SIGNATURE <i>Charles S. Thomas</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07010

7023		1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Green Acres c. LENGTH OF STAY IN lb 2 weeks d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5319 Wakefield Road										2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE New York b. COUNTY Rensselaer c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Schenectady d. STREET ADDRESS 36 Swan Street	
3. NAME OF DECEASED (Type or print)		First FRED		Middle H.		Last SCOTT		4. DATE OF DEATH June 15 1961		Month Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 29 1882		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 9 Days 16 IF UNDER 24 HRS. Hours 9 Min. 16			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Carpenter		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Nowell Scott		14. MOTHER'S MAIDEN NAME Clara Hynds		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Yes Unknown		17. INFORMANT Leo Scott-Son-same as 1d		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion INTERVAL BETWEEN ONSET AND DEATH Sudden DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension years DUE TO (c)											
19. WAS AUTOPSY PERFORMED? NO		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetic mellitus 6 years											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While at work											
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bramanville Cemetery		20f. (City or town) Bramanville		(County) New York		(State) NY			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 6/15/61					
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 6/20/61		22c. NAME OF CEMETERY OR CREMATORIUM Bramanville Cemetery		22d. LOCATION (City, town, or county) Bramanville		(State) New York					
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR John L. Koenig		24b. REGISTRAR'S SIGNATURE John L. Koenig		DATE JUN 19 '61					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7024

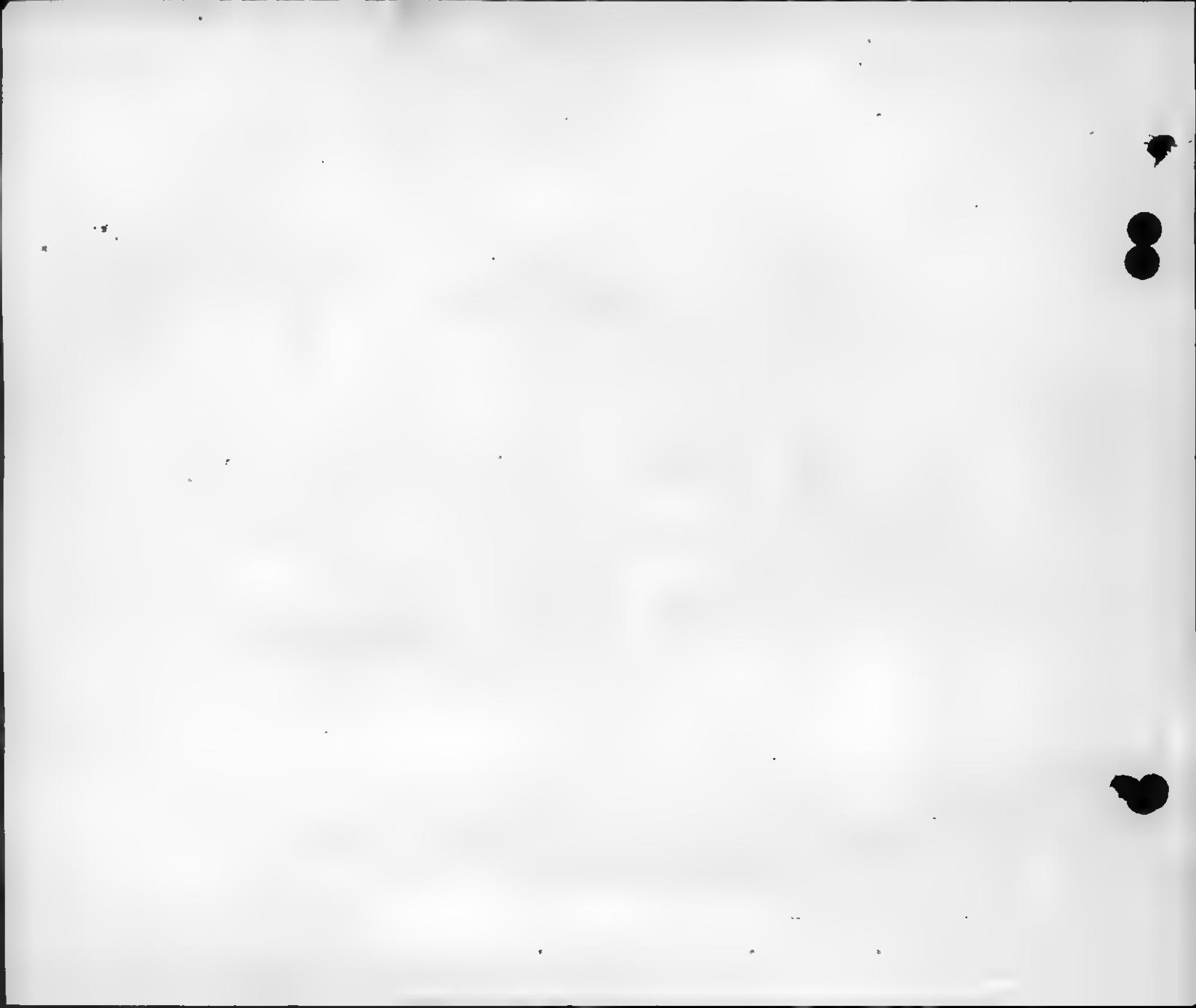
CERTIFICATE OF DEATH

07017

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) b. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington Grove	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hospital			d. STREET ADDRESS Brown Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Sarah		First Wall	Middle Seaton	Last	4. DATE OF DEATH Month 6 Day 4 Year 1961
S. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 7/1/1880	9. AGE (In years last birthday) 81 80 ^{rs}	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY M M		11. BIRTHPLACE (State or foreign country) England	
13. FATHER'S NAME Andrew Wall			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 122.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Heart Failure Chronic Myocarditis					
19. INTERVAL BETWEEN ONSET AND DEATH					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 29 1961, to June 5, 1961, that (I) (we) last saw the deceased alive on July 4, 1961, and that death occurred at 11:15 PM, from the causes and on the date stated above.					
22a. SIGNATURE Luciano I. Leal			22b. DATE SIGNED June 4, 1961		
22c. PHYSICIAN'S NAME (Type) Luciano I. Leal			22d. ADDRESS Gaithersburg Md.		
23a. BURIAL, CREMATION REMOVAL (Specify) Cremation 6-7-61		23b. DATE THEREOF Ft. Lincoln		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	
24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner.			23d. LOCATION (City, town, or county) Md. Gaithersburg Md. 25a. REC'D BY REGISTRAR DATE JUN 7 '61 25b. REGISTRAR'S SIGNATURE Loring S. Krause		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed with the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07012

7025

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 47 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 12101 Portree Road		4. DATE OF DEATH SELL		Month June		Dey 16		Year 1961	
3. NAME OF DECEASED (Type or print) Petrina Augusta		5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED WIDOWED		8. DATE OF BIRTH 6-28-04		9. AGE (In years last birthday) 56 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.	
13. FATHER'S NAME Hallgrimur GOTTSKALKSON		14. MOTHER'S MAIDEN NAME Ingbjorg FOSS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (S) Lt. K. W. Sell, MC, USN, same as #2 above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 110X		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. b		INTERVAL BETWEEN ONSET AND DEATH 1 yr.		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 10:07 AM		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Rockville		(County) Maryland		(State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 30, 1961 to June 16, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 16, 1961 , and that death occurred at M., from the causes and on the date stated above.		22a. SIGNATURE <i>G. W. D. Hoofer</i>		M.D.		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) W. D. HOOFER, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.								22b. DATE SIGNED 6-16-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-19-61		23c. NAME OF CEMETERY OR CREMATORIAL Rockville Cemetery		23d. LOCATION (City, town or county) Rockville		23e. (State) Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Tyson Wheeler</i>		ADDRESS Tyson Wheeler Funeral Home, Rockville, Md.		25a. REC'D BY REGISTRAR JUN 21 '61		25b. REGISTRAR'S SIGNATURE <i>James L. Thomas</i>					
VR A15 (4) 15M 9/60											

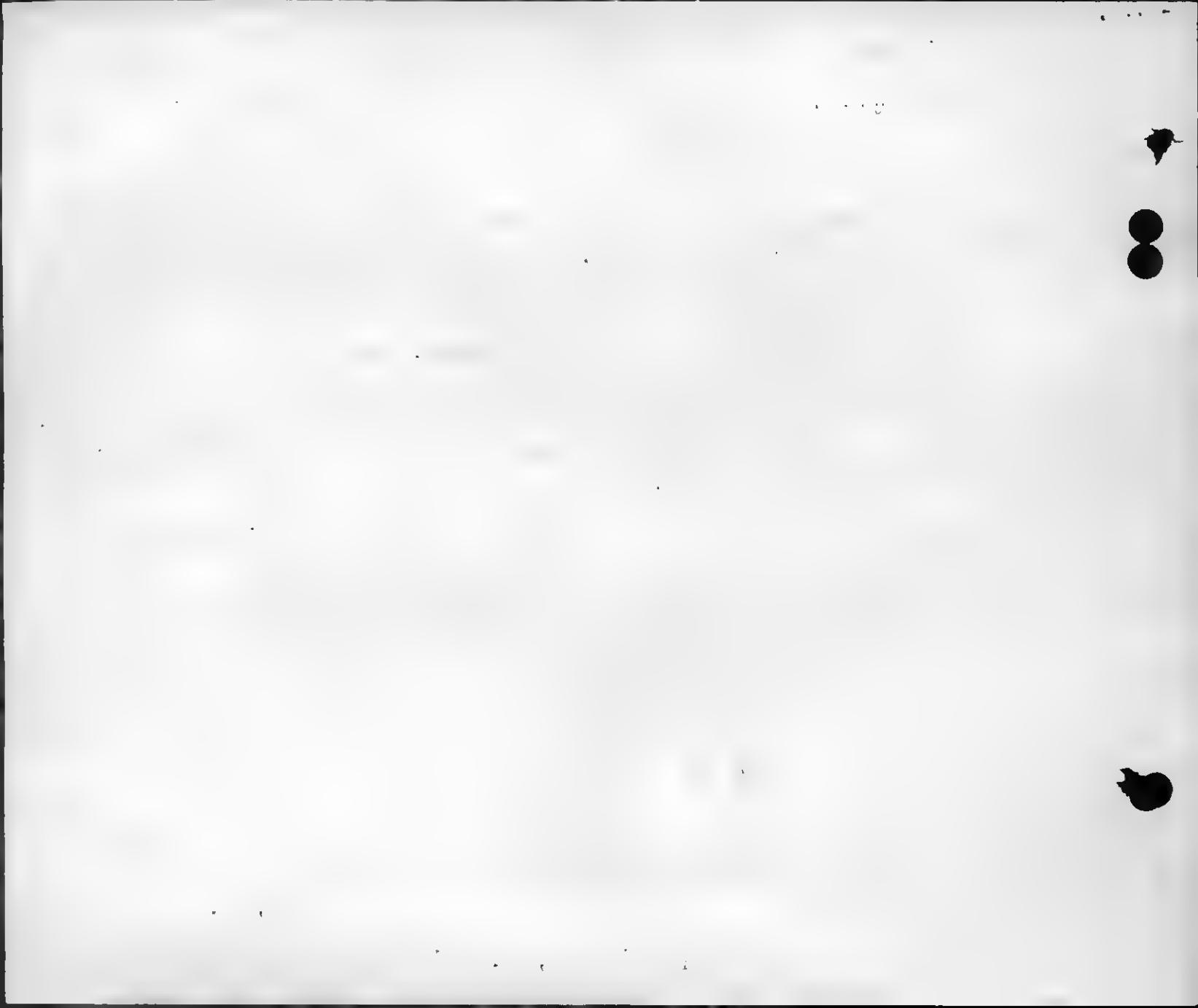


MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7026

07013

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. STREET ADDRESS 5917 - LeMay Road	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Hilda	Middle L.	Last Shafer
4. DATE OF DEATH	Month 6	Day 14	Year 19 61
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1/30/21
9. AGE (In years last birthday) 40 yrs	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Taunton, Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Jones		14. MOTHER'S MAIDEN NAME Hilda Hathaway	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-18-0054	
17. INFORMANT Miss Janice Jones		Address Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a).		INTERVAL BETWEEN ONSET AND DEATH 3 w	
170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Cerebral Edema		(c) DUE TO Carcinoma, breast Metastases 18m	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/31 , 19 61 , to 6/14 , 19 61 , that (II) (we) last saw the deceased alive on 6/14 , 19 61 , and that death occurred at 325M , from the causes and on the date stated above.		22b. DATE SIGNED 6/15/61	
22a. SIGNATURE J. H. Tracy, M.D.		22b. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) J. H. TRACY, M.D.		22d. ADDRESS 7720 WISCONSIN AV BETHESDA 14, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/17/61	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Parklawn		23d. LOCATION (City, town, or county) (State) Rockville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheler		25a. REC'D BY REGISTRAR DATE JUN 19 '61	
25b. REG. STRR'S SIGNATURE James S. Thrus			



12
FOR STATE
HEALTH DEPT.

M

199

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07014

7627

1. PLACE OF DEATH
a. COUNTY MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park DOA.

c. LENGTH OF STAY IN IB

d. NAME OF HOSPITAL OR INSTITUTION (if not a hospital, give street address) 1115 Sh. 1222 & H St. First Middle

3. NAME OF DECEASED (Type or print) Bertha Feffer Shantz

4. SEX f 6. COLOR OR RACE Wh 7. MARRIED NEVER MARRIED b. DATE OF BIRTH 8. DATE OF DEATH 1-1-1894 9. AGE (in years last birthday) 67 yrs. IF UNDER 1 YEAR Months Dey 10. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) HOUSE WIFE 10b. KIND OF BUSINESS OR INDUSTRY - 11. BIRTHPLACE (State or foreign country) RUSSIA 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME PHILLIP FEFFER UNKNOWN Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? No 16. SOCIAL SECURITY NO. 17. INFORMANT UNKNOWN MR. IRVING SHANTZ

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) DUE TO Coronary occlusion
Conditions, if any, which
give rise to immediate cause (b) DUE TO sudden death
(c) DUE TO hypertension

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a),

20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While at work Not While at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

Hour a.m. p.m. 19

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes Accident , Suicide , Homicide , Undetermined manner

ACTUAL NAME (Type) Frank J. Boeschert CHIEF MEDICAL EXAMINER
DEATHBED NAME (Type) Frank J. Boeschert ASSISTANT MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER DATE SIGNED 6-16-61

Address (Street, city, town, or county)

22a. CERIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIUM 22d. LOCATION (City, town, or county) (State)

BURIAL 6/18/61 MT. ZION MASSETH, L.I.

23. FUNERAL DIRECTOR ADDRESS 4217 REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE
Goldberg Funeral Home 9th & Lee JUN 19 1961 Arthur S. Price

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If it cannot be done within 24 hours, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2
Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
SM 9 60



MARYLAND STATE DEPARTMENT OF HEALTH

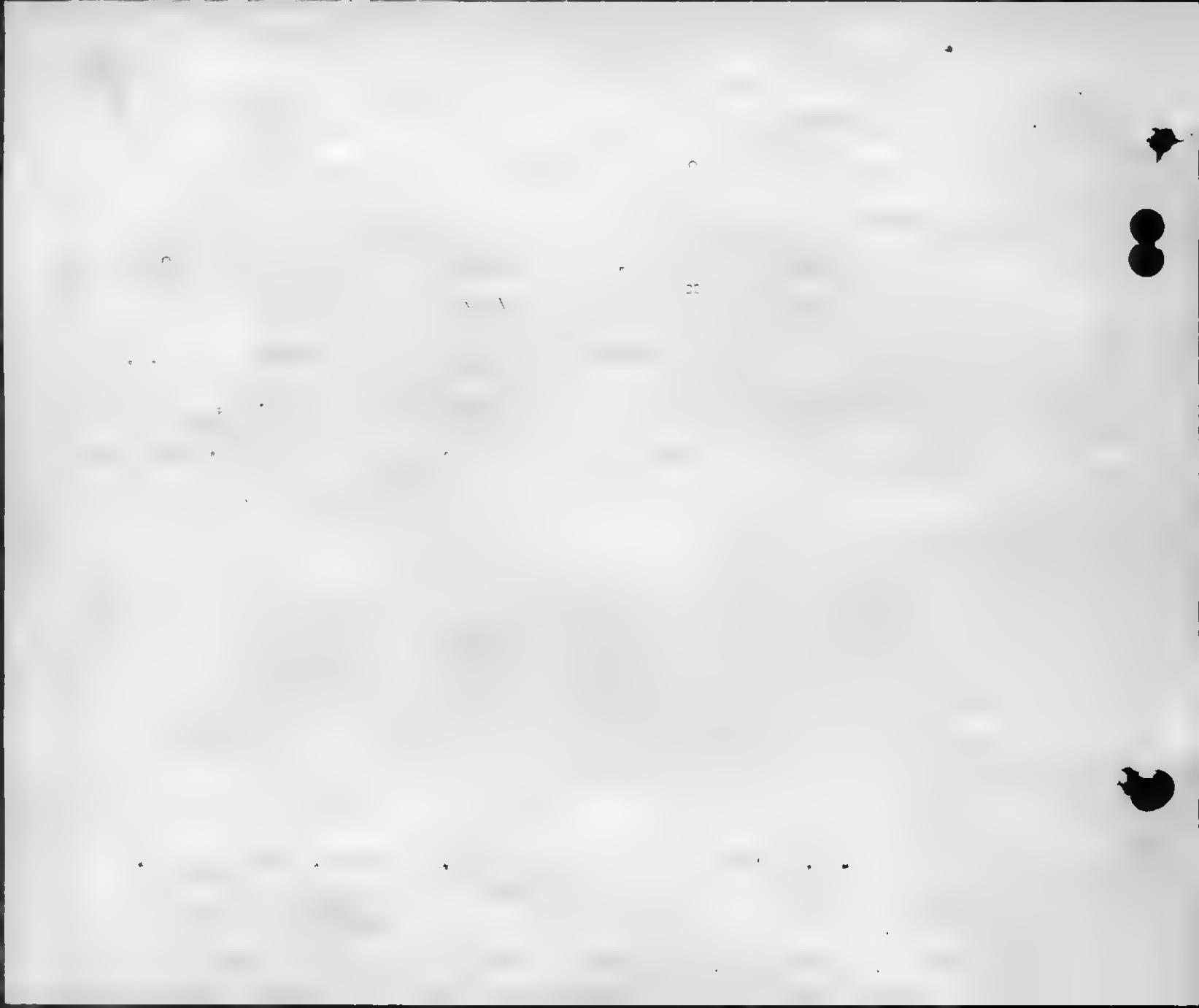
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7028

07015

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		b. COUNTY CARROLL	
c. LENGTH OF STAY IN 1b 2 DAYS 8 HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SUBURBAN		d. STREET ADDRESS 1101 - 1/2 Acre	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First LILLIAN	Middle R.	Last SHIPLEY
4. DATE OF DEATH	Month JUNE	Day 22	Year 19 61
5. SEX	6. COLOR OR RACE FEMALE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8/27/86
9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. BIRTHPLACE (County & State, or foreign country) Home	12. CITIZEN OF WHAT COUNTRY? MARION STATION, MARYLAND U.S.
13. FATHER'S NAME GEORGE THOMAS MADDOX	14. MOTHER'S MAIDEN NAME EVELYN DORSEY	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT MARGARET L. SHIPLEY	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause first. (b) DUE TO (c) Arteriosclerotic Heart Disease 15 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rockville, Md.
20f. (City or town) Rockville	(County) Maryland	(State) Md.	22b. DATE SIGNED 22 June 61
21. I certify that (I) (this hospital) attended the deceased from Dec 1959 to July 1961 , that (I) (we) last saw the deceased alive on 21 June 1961 , and that death occurred at 8 A.M. from the causes and on the date stated above.		22c. PHYSICIAN'S NAME (Type) W. S. Murphy	
22d. ADDRESS 615 W. Montgomery, Rockville, Md.	ATTENDING PHYS. <input checked="" type="checkbox"/> M.D.	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22e. SIGNATURE W. S. Murphy
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-26-61	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Springfield Cemetery, Rockville, Md.	23d. LOCATION (City, town or county) Rockville, Carroll, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Haught, Rockville, Md.	25a. REC'D BY REGISTRAR Arthur H. Haught	25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	DATE JUN 26 '61



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7029

CERTIFICATE OF DEATH

07016

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4 of this certificate is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as this burial permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

M

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Takoma Park

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington Sanitarium and Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

5. SEX

Female White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

13. FATHER'S NAME

Jacob Minkin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

No

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

157X

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last. } (b)

DUE TO

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

20e. ACCIDENT WAS UNDERLYING] | 2db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING] CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 192dd. INJURY OCCURRED
While at work Not While at work

2de. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 5-26, 1961 to 6-13, 1961, that (I) (we) last saw the deceased alive on 6-12, 1961, and that death occurred at 5-26, from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

23a. BURIAL, CREMATION, DATE THEREOF
REMOVAL (Specify)
Cremation 6/14/61

24. FUNERAL DIRECTOR'S SIGNATURE

Abraham W. Danis

M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

22d. ADDRESS

23b. NAME OF CEMETERY OR CREMATORIUM
Geo. Wash. Cem.

23c. LOCATION (City, town or county)

(State)

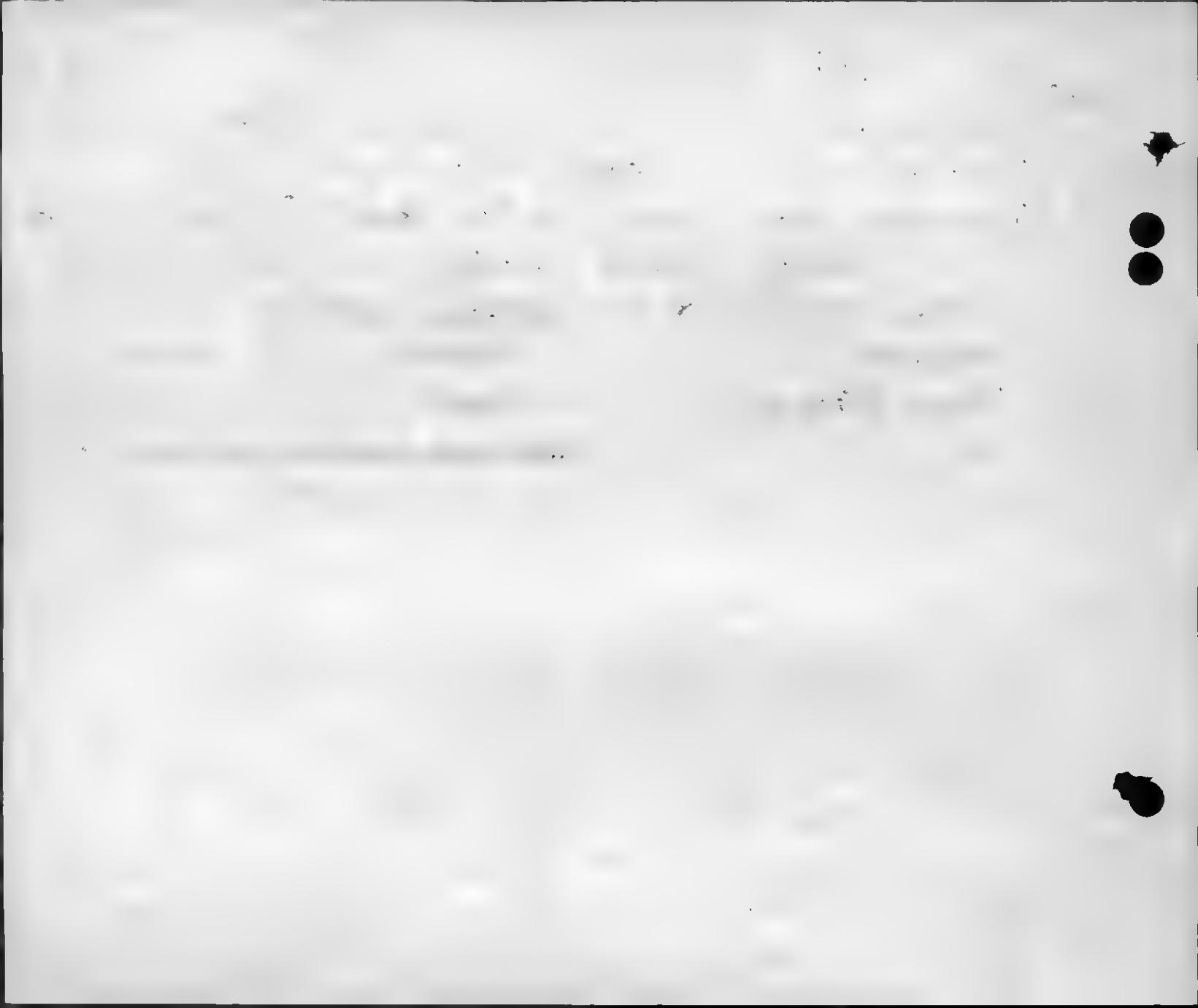
ADDRESS
4117 - Bee St. NW

25e. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE JUN 14 '61

Carla S. Tamm



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by a retained hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH			07017		
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived — If institution, Residence before admission)													
<i>Montgomery</i>				a. STATE <i>DC</i>													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				b. COUNTY													
<i>Takoma Park</i>																	
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)													
<i>2 1/2 weeks.</i>				<i>Washington</i>													
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS													
<i>517 Albany Avenue Oakhaven Convalescent Home</i>				<i>1707 Columbia Road N.W.</i>													
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print)				First	Middle	Last	4. DATE OF DEATH	Month	Day	Year							
<i>Tallulah de Sales</i>						<i>Smith</i>	<i>June</i>	<i>30</i>	<i>1961</i>								
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH				9. AGE (In years (at birthday))	10. IF UNDER 1 YEAR IF UNDER 24 HRS								
<i>F</i>		<i>W</i>	<i>Feb. 21, 1882</i>					<i>79</i> yrs	Months	Days	Hours						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)									
<i>Gov't Worker - Claim Clerk</i>				<i>Vet. Admin.</i>				<i>Texas</i>									
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?									
<i>Dr. Zadoc Baker</i>				<i>Tallulah Abrams</i>				<i>U.S.</i>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT									
<i>No</i>				<i>no</i>				<i>Mrs John Moulder 1107 Merwood Dr. Takoma Park Md.</i>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)																	
17 IX Conditons, if any, which gave rise to immediate cause (a), stating the under- lying cause last } DUE TO (b) <i>UREMIA</i>																	
DUE TO (c) <i>METASTATIC CARCINOMA</i>																	
DUE TO (c) <i>CARCINOMA OF THE CERVIX</i>																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
19																	
21. I certify that (I) (this hospital) attended the deceased from <i>OCT 1960 to 30 1961</i> , that (I) (we) last saw the deceased alive on <i>16 29 1961</i> , and that death occurred at <i>6 AM</i> , from the causes and on the date stated above.																	
22a. SIGNATURE <i>Merrill C. Quinnan Jr.</i>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) <i>MERRILL C QUINNAN JR MD</i>				22d. ADDRESS <i>7600 Carroll Ave Takoma Park MD</i>													
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM				23d. LOCATION (City, town, or county) (State)									
<i>Burial</i>		<i>7/1/61</i>		<i>Rock Creek Cemetery</i>				<i>Washington, D.C.</i>									
24. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co. - Washington 9, D.C.</i>				ADDRESS <i>2901 14th St., N.W.</i>				25a. REC'D BY REGISTRAR <i>JUL 3 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4 is to be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7031

07018

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda (Rural)

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

U.S. NAVAL HOSPITAL, NNM, BETHESDA, MD.

3. NAME OF
DECEASED
(Type or print)

Dennis

Keith

SMITHERS

5. SEX

Male

6. COLOR OR RACE

Cauc

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

1-13-82

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

U.S. Marine Corps

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State or foreign country)

Virginia

13. FATHER'S NAME

Howard S. SMITHERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOC AL SECURITY NO. 17. INFORMANT
(Yes, no, or unknown) (If yes give war record of service)

Yes **Unknown**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420

DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Myocardial Infarction
Arteriosclerotic Heart Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES **NO**

20a. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
p.m. 19 While at work Not While at work 20f. (City or town)
(County) (State)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

21. I certify that **W.P. BAKER LT MC USN** attended the deceased from **10 June 1961** to **23 June 1961**, that **W.P. BAKER LT MC USN** last saw the deceased alive on **23 June 1961**, and that death occurred **9:20PM** from the causes and on the date stated above.

22a. SIGNATURE

William P. Baker

22c. PHYSICIAN'S
NAME (Type)

W.P. BAKER LT MC USN

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22d. ADDRESS

6-24-61

22b. DATE
SIGNED

U.S. Naval Hospital, Bethesda, Maryland

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

6-26-61

23c. NAME OF CEMETERY OR CREMATORIUM

Rock Creek

23d. LOCATION (City, town or county)

(State)

Church Road, N.W., Washington, DC

24. FUNERAL DIRECTOR'S SIGNATURE

W.E. Pumphrey Funeral Home

25a. REC'D BY REGISTRAR

Chilton S. Thomas

25b. REGISTRAR'S SIGNATURE

Chilton S. Thomas

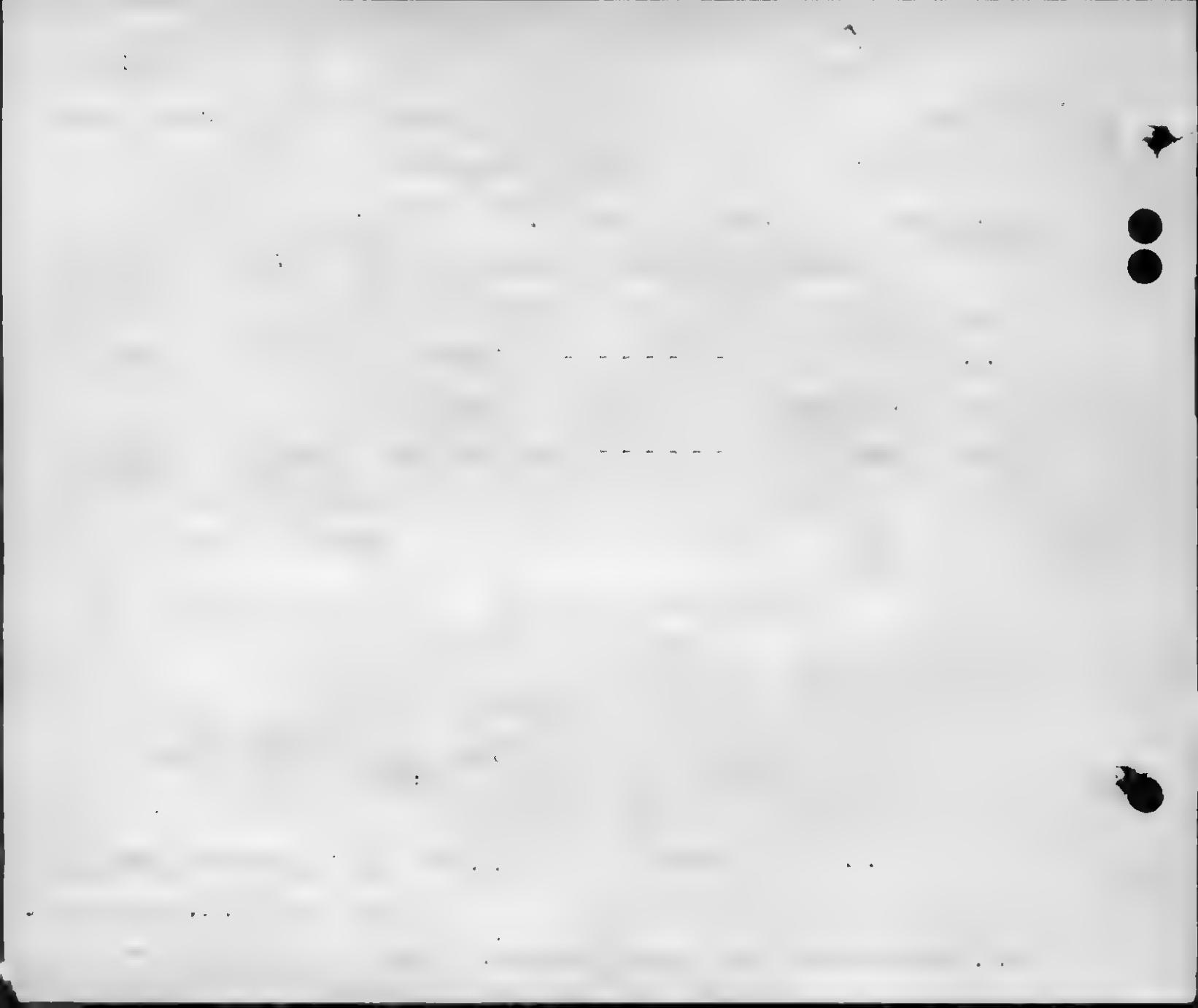
within 24 hrs after

M

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07019

1. PLACE OF DEATH 7032

a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits
write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN 1b

MARYLAND

29 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Suburban

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

ELIA

R.

SNAPP

5. SEX

6. COLOR OR RACE

Female

White

10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

February 26 1875

86 yrs.

6201 12th St NW

June 7

1961

4. DATE
OF
DEATH

Month

Dey

Year

9. AGE (In years
last birthday)

Months

Days

10. IF UNDER 1 YEAR

Hours

Min.

13. FATHER'S NAME

JOHN SHIRLEY

REBECA

NAGLEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.

(Yes, no, or unknown) (If yes give war dates of service)

17. INFORMANT

Lola V. Kelley (Niece)

Address

1101 Amherst Dr.
Silver Spring, Md.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

VIRGINIA USA

14. MOTHER'S MAIDEN NAME

18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Arteriosclerotic heart disease

INTERVAL BETWEEN
ONSET AND DEATH

16 yrs

DUE TO

Conditions, if any, which
gave rise to Immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Generalized Arteriosclerosis

20 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I(e)

Diabetes Mellitus

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MED CAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While at work Not While at work
p.m. 19 20d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from July 1, 1951, to June 8, 1961, that (I) (we) last
saw the deceased alive on June 7, 1961, and that death occurred at 11:30 P.M. from the causes and on the date stated above

22a. SIGNATURE

John E. Everett M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED

6/8/61

22c. PHYSICIAN'S
NAME (Type)

JOHN E. EVERETT

22d. ADDRESS

9400 Conn. Ave KENSINGTON MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county)

(State)

BURIAL 6-10-61

MT. HERBON

WINCHESTER VA

24 FUNERAL DIRECTOR'S SIGNATURE

DEAL FUNERAL HOME 4812 Daingerfield
Woolard

ADDRESS

25e. REC'D BY REGISTRAR

(State)

25b. REGISTRAR'S SIGNATURE

Charles S. Kline

DATE JUN 12 '61

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Within 24 hours after

M

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7033

07020

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rural

MARYLAND

c. LENGTH OF STAY IN 1b

7 mos. 3 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Waverley Sanitarium

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATHMonth
JuneDay
20Year
19 61

5. SEX

Female

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

2-12-1882

9. AGE (In years
last birthday)79
yrs.10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)IF UNDER 1 YEAR
Months Days11. IF UNDER 24 HRS.
Hours Min.

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Buffalo, New York

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Nathaniel W. Norton

14. MOTHER'S MAIDEN NAME

Mary C. Minor

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

No

16. SOC. SECURITY NO.

(Yes, no, or unknown) (If yes, give rank and dates of service)

17. INFORMANT

Mrs Henry Day, 3252 O St., N.W. Wash. 7 D.C.

Address

18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (s)

Cerebral Thrombosis

2X

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

Arteriolosclerosis Generalized

DUE TO

(c)

Senility

INTERVAL BETWEEN
ONSET AND DEATH

3 mont hs

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO

Chronic Nephritis (Nephrosclerosis)

20a. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.20d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)
20f. (City or town)
(County) (State)21. I certify that (I) (this hospital) attended the deceased from 11-17-60 to 6-20-61 that (I) (we) last
saw the deceased alive on 6-20-1961, and that death occurred at 12:30 p.m. from the causes and on the date stated above.

22a. SIGNATURE

Frederick J. Chapman

ATTENDING
PHYS.

MED. DIRECTOR

STAFF
PHYS.22b. DATE
SIGNED22c. PHYSICIAN'S
NAME (Type)

22d. ADDRESS

1150 Curr Ave. New

23a. BURIAL, CREMATION, 23b. DATE THEREOF
REMOVAL (Specify)

Burial 6/23/61

23c. NAME OF CEMETERY OR CREMATORIAL

St. Michael's churchyard

23d. LOCATION (City, town or county) (State)

Litchfield, Connecticut.

24 FUNERAL DIRECTOR'S SIGNATURE

Fay F. Bishop
3034 m Street, N.W.
R. & Haycock, Inc.

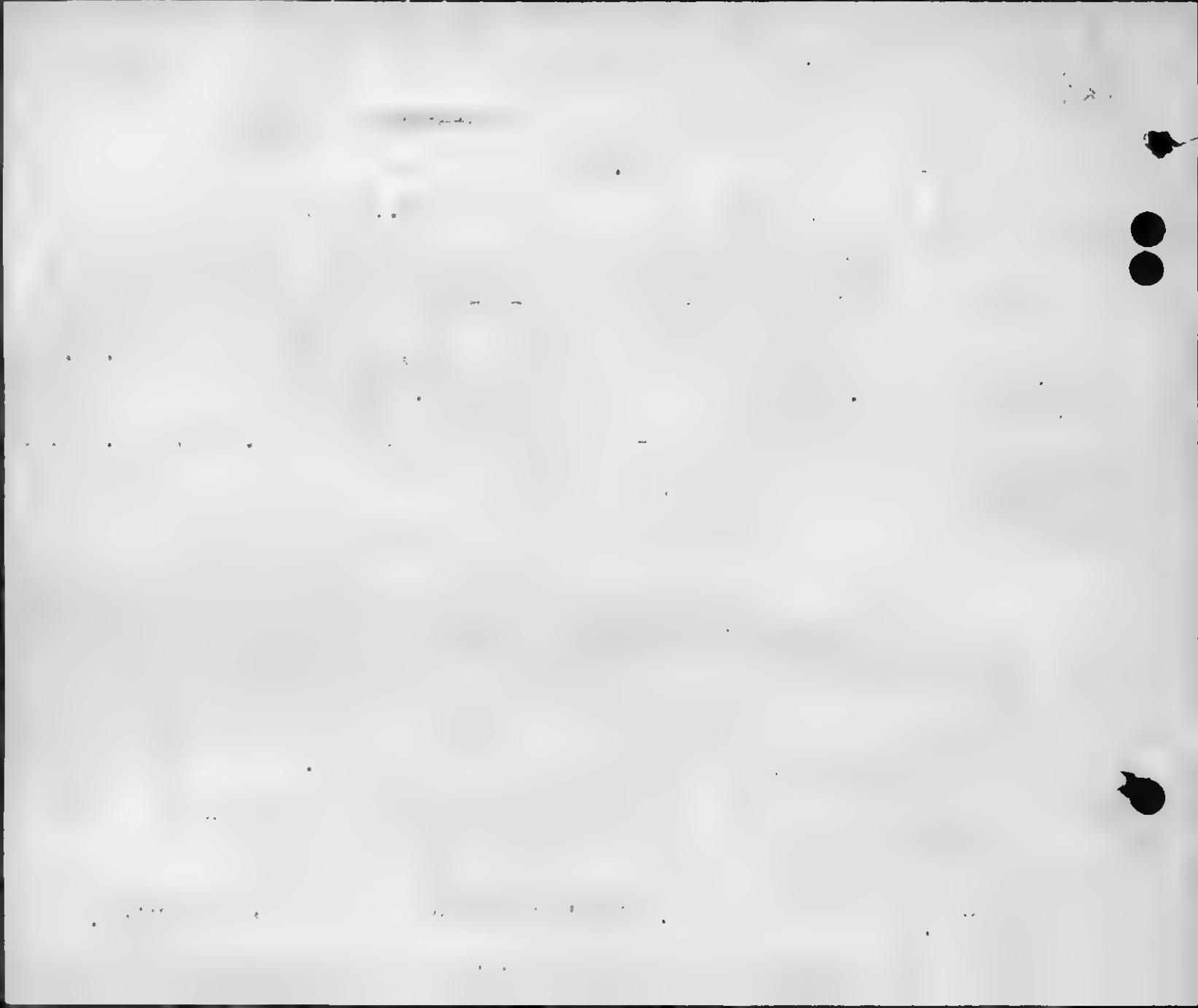
25a. REC'D BY REGISTRAR

JUN 22 '61

DATE

25b. REGISTRAR'S SIGNATURE

Arthur S. Kline



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07021

7034

1. PLACE OF DEATH
a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

c. LENGTH OF STAY IN 1b

MARYLAND

13 years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

10,026 Lorain Avenue

First

Middle

3. NAME OF
DECEASED
(Type or print)

August

P.

5. SEX

White

Male

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Chef.

13. FATHER'S NAME

Guy Spigone

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war record or service No

No

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

420.1

Coronary Occlusion

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)

DUE TO

Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c)

DUE TO

Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.

19. WAS AUTOPSY PERFORMED?

YES NO

16. SOCIAL SECURITY NO. 17. INFORMANT

577-14-3495 Miss Violet Spigone, 10,026 Lorain Ave., SS., Md.

Address

INTERVAL BETWEEN
ONSET AND DEATH

Sudden

20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH.

2db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Diabetes Mellitus -----Years

20c. TIME OF INJURY Month, Day, Year

Hour e.m.
p.m.

20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

While at work at work

20e. (City or town) (County) (State)

19

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

ACTUAL SIGNATURE *Frank J. Groschart*

EXAMINER'S NAME (Type)

M.D.

ASSISTANT MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

6/16/61

Address (Street, city, town, or county)

22d. LOCATION (City, town, or country) (State)

22e. BURIAL, CREMATION, REMOVAL (Specify)

22c. NAME OF CEMETERY OR CREMATORIAL

Burial June 20, 1961 Fort Lincoln Cemetery Prince George's County, Md.

23. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. Silver Spring, Md.

ADDRESS

24e. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

JUN 22 '61

DATE

Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Please execute in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07022

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for 7 years.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Montgomery</i> MARYLAND		<i>Md</i> <i>Monty</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>315 Broadwood Dr</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>Michael</i>	Middle <i>John</i>
		Last <i>Stahl</i>	4. DATE OF DEATH Month <i>June</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>4-22-61</i>		9. AGE IN YEARS (at birth) <i>0</i> yrs.	10. IF UNDER 1 YEAR Months <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>—</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>Md</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>—</i>		14. MOTHER'S MAIDEN NAME <i>Mary Stahl</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Family Service Monty Co - Rockville Md</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>415X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Final dead in bed</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>—</i>		DUE TO (b) <i>upper Respiratory Infection</i>	
DUE TO (c) <i>—</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year <i>19</i>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED <i>6-3-61</i>	
ACTUAL SIGNATURE <i>Frank J. Broeschelt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Frank J. Broeschelt</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/6/61</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Lishburn</i>		22d. LOCATION (City, town, or county) <i>Harrisburg, Pennsylvania</i>	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home Rockville, Md.		ADDRESS 1331 E. Montg. Ave., Rockville, Md.	
		24a. REC'D BY REGISTRAR JUN 7 '61	
		24b. REGISTRAR'S SIGNATURE <i>Colvin S. Treanor</i>	





1
after d
2036
M

TO HOSPITAL OR
may be retained by
TO FUNERAL DIRECTOR
After this certificate has been signed by the attending physician and completely filled in by the funeral director.
Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07023

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN lb 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				d. STREET ADDRESS R-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First CHARLES	Middle WILLIAM	Last STANG	4. DATE OF DEATH JUNE 19, 1961	Month	Day	Year
---	-------------------------	--------------------------	----------------------	--	-------	-----	------

5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Jan 2nd 1874	9. AGE (In years last birthday) 87	IF UNDER 1 YEAR Months 8	IF UNDER 24 HRS Hours 1	Year Min
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA
---	-----------------------------------	--	--

13. FATHER'S NAME FREDERICK STANG	14. MOTHER'S MAIDEN NAME Reosealthe Mossburg
---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) (If yes, give war or date of service)	16. SOCIAL SECURITY NO	17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	<i>Heart Failure</i>		
351X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.	DUE TO (b)	<i>Cerebral Vascular Accident.</i>	
	DUE TO (c)	<i>Hypertension</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
--

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
---	--	--	--

20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
--	--	---	--------------------------------------

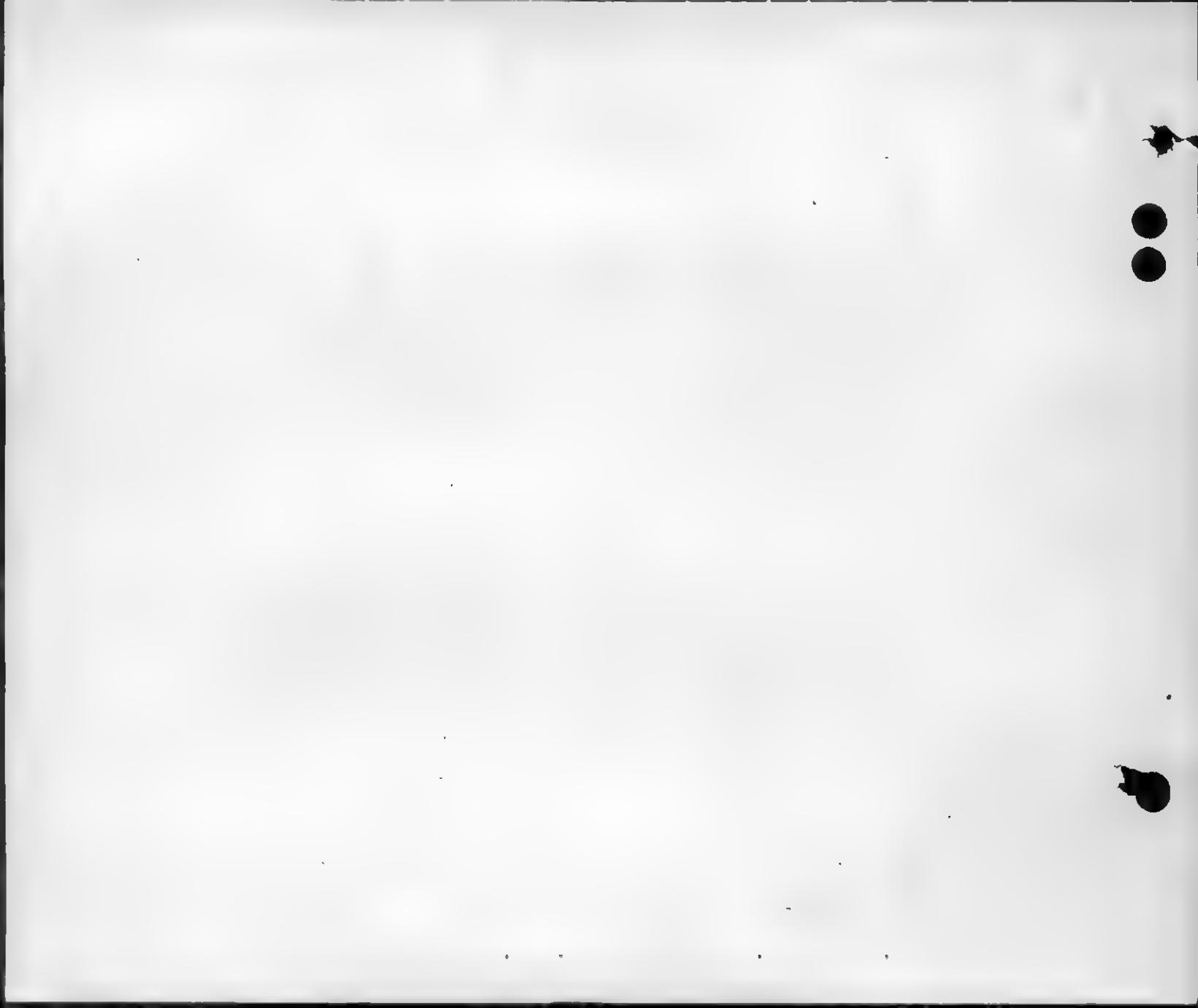
21. I certify that (I) (this hospital) attended the deceased from 6/13/61 to 6/19/61 , that (I) (we) last saw the deceased alive on 6/19/61 , and that death occurred 6/19/61 at 10:45 AM , from the causes and on the date stated above.
--

22a. SIGNATURE <i>Lucius L. Leal</i>	M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 6/21/61
---	--	------------------------------------

22c. PHYSICIAN'S NAME (Type) L. L. LEAL, M. D.	22d. ADDRESS GAITHERSBURG, MARYLAND	
--	---	--

23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 6-21-61	23c. NAME OF CEMETERY OR CREMATORIAL Forest Oak	23d. LOCATION (City, town, or county) Gaithersburg (State) Md.
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24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg. Md.	ADDRESS	25a. REC'D BY REGISTRAR JUN 21 '61	25b. REG-STRAR'S SIGNATURE <i>C. Gartner & Son</i>
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7037

07024

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
Montgomery				a. STATE	Maryland
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 16		b. COUNTY	Montgomery
Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Silver Spring		e. IS RESIDENCE ON A FARM?	
Carroll Hall Sanitarium 10231 Carroll Place				d. STREET ADDRESS	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First	Middle	4. DATE OF DEATH	Month	Day
Alverda		Summers	June	19,	1961
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Dey
female	white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	2/3/1867	94 yrs	IF UNDER 24 HRS. Hours Min.
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b. KIND OF BUSINESS OR INDUSTRY		11c. BIRTHPLACE (County & State, or foreign country)	
Housewife				Virginia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
William B. Curtis		Hannah Montgomery		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
no				Address Records at Sanitarium-Kensington, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Paralytic Ileus					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO Generalized Arteriosclerosis					
(c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 4 1956 to June 19, 1961, that (I) (we) last saw the deceased alive on June 18 1961, and that death occurred at 1035 A.M. from the causes and on the date stated above.					
22a. SIGNATURE Arthur H. Lewis					
22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type)		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS ARTHUR H. LEWIS MD 1714 R I Ave NW Wash DC	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL	
Burial		6/21/1961		23d. LOCATION (City, town or county) Washington, D.C. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St. N.W. Washington 9, D.C.					
ADDRESS					
25a. REC'D BY REGISTRAR					
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas JUN 20 '61					

TO HOSPITAL
death. Page 4
referred by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4
VR A15 (4)
15M 9/60

...DADOC

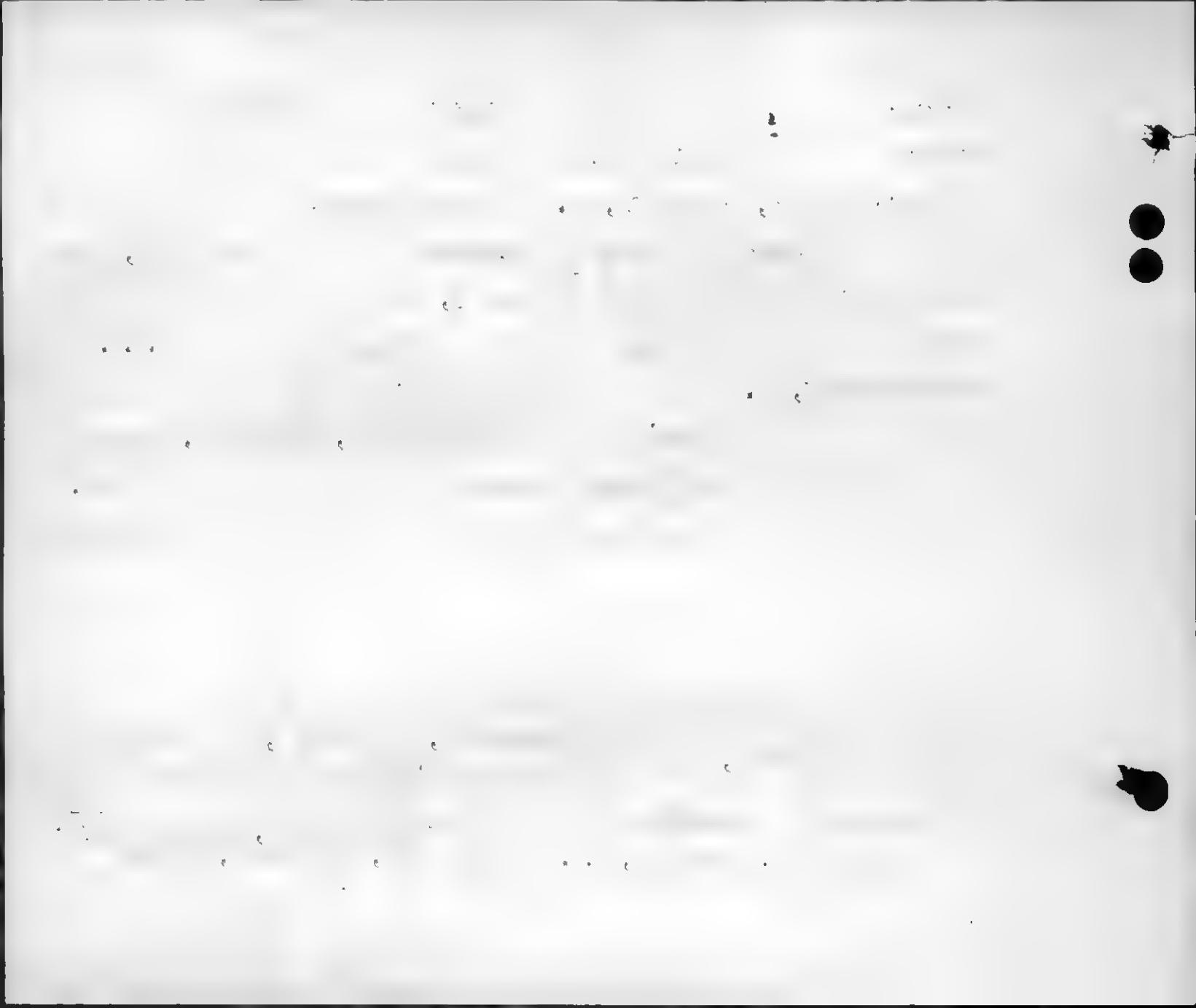
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7038		050		07025	
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution, residence before admission) a. STATE Virginia b. COUNTY Fairfax			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 171 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Anacostia		f. STREET ADDRESS No street address	
g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) James Benny Sutherland		First James	Middle Benny	Last Sutherland	4. DATE OF DEATH June 4, 1961
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1944	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		9. AGE (In years last birthday) 17 yrs	
				10c. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Denny Sutherland, Jr.		14. MOTHER'S MAIDEN NAME Faye Harrison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Lymphatic Leukemia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gram Negative Septicemia DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 9 mos. 1 week	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 4, 1961 , and that death occurred at		December 15, 1960 , 60 June 4, 1961 , 61		4:00 PM to 19 19 19 19 that (I) (we) last saw the deceased alive on June 4, 1961 , 19 , and that death occurred at M , from the causes and on the date stated above.	
22a. SIGNATURE Richard E. Rieselbach		M.D. ATTENDING PHYS <input type="checkbox"/> 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland		22b. DATE SIGNED 6-5-61	
22c. PHYSICIAN'S NAME (Type) RICHARD E. RIESELBACH, M.D.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/6/61		23c. NAME OF CEMETERY OR CREMATORIAL -	
24. FUNERAL DIRECTOR'S SIGNATURE John W. Chamberlain Co.		ADDRESS 1400 Chapman St. N.W.		25a. REC'D BY REGISTRAR JUN 7 '61	
				25b. REGISTRAR'S SIGNATURE John S. Chase	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7039

67026

CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

Montgomery
Silver Spring

MARYLAND

c. LENGTH OF STAY IN 16

12 yrs.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

10.614 Edgewood Avenue

3. NAME OF
DECEASED
(Type or print)

Rosalie

First

Middle

B

Taylor

5. SEX

6. COLOR OR RACE

7. MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

90 Aug 1897

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

11. KIND OF BUSINESS OR INDUSTRY

12. BIRTHPLACE (County & State, or foreign country)

13. FATHER'S NAME

14. MOTHER'S M AIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

18. AGE (In years (last birthday))

19. IF UNDER 1 YEAR

20. IF UNDER 24 HRS.

21. IF UNDER 6 MONTHS

22. IF UNDER 12 MONTHS

23. IF UNDER 18 MONTHS

24. IF UNDER 24 MONTHS

25. IF UNDER 30 MONTHS

26. IF UNDER 36 MONTHS

27. IF UNDER 42 MONTHS

28. IF UNDER 48 MONTHS

29. IF UNDER 54 MONTHS

30. IF UNDER 60 MONTHS

31. IF UNDER 66 MONTHS

32. IF UNDER 72 MONTHS

33. IF UNDER 78 MONTHS

34. IF UNDER 84 MONTHS

35. IF UNDER 90 MONTHS

36. IF UNDER 96 MONTHS

37. IF UNDER 102 MONTHS

38. IF UNDER 108 MONTHS

39. IF UNDER 114 MONTHS

40. IF UNDER 120 MONTHS

41. IF UNDER 126 MONTHS

42. IF UNDER 132 MONTHS

43. IF UNDER 138 MONTHS

44. IF UNDER 144 MONTHS

45. IF UNDER 150 MONTHS

46. IF UNDER 156 MONTHS

47. IF UNDER 162 MONTHS

48. IF UNDER 168 MONTHS

49. IF UNDER 174 MONTHS

50. IF UNDER 180 MONTHS

51. IF UNDER 186 MONTHS

52. IF UNDER 192 MONTHS

53. IF UNDER 198 MONTHS

54. IF UNDER 204 MONTHS

55. IF UNDER 210 MONTHS

56. IF UNDER 216 MONTHS

57. IF UNDER 222 MONTHS

58. IF UNDER 228 MONTHS

59. IF UNDER 234 MONTHS

60. IF UNDER 240 MONTHS

61. IF UNDER 246 MONTHS

62. IF UNDER 252 MONTHS

63. IF UNDER 258 MONTHS

64. IF UNDER 264 MONTHS

65. IF UNDER 270 MONTHS

66. IF UNDER 276 MONTHS

67. IF UNDER 282 MONTHS

68. IF UNDER 288 MONTHS

69. IF UNDER 294 MONTHS

70. IF UNDER 300 MONTHS

71. IF UNDER 306 MONTHS

72. IF UNDER 312 MONTHS

73. IF UNDER 318 MONTHS

74. IF UNDER 324 MONTHS

75. IF UNDER 330 MONTHS

76. IF UNDER 336 MONTHS

77. IF UNDER 342 MONTHS

78. IF UNDER 348 MONTHS

79. IF UNDER 354 MONTHS

80. IF UNDER 360 MONTHS

81. IF UNDER 366 MONTHS

82. IF UNDER 372 MONTHS

83. IF UNDER 378 MONTHS

84. IF UNDER 384 MONTHS

85. IF UNDER 390 MONTHS

86. IF UNDER 396 MONTHS

87. IF UNDER 402 MONTHS

88. IF UNDER 408 MONTHS

89. IF UNDER 414 MONTHS

90. IF UNDER 420 MONTHS

91. IF UNDER 426 MONTHS

92. IF UNDER 432 MONTHS

93. IF UNDER 438 MONTHS

94. IF UNDER 444 MONTHS

95. IF UNDER 450 MONTHS

96. IF UNDER 456 MONTHS

97. IF UNDER 462 MONTHS

98. IF UNDER 468 MONTHS

99. IF UNDER 474 MONTHS

100. IF UNDER 480 MONTHS

101. IF UNDER 486 MONTHS

102. IF UNDER 492 MONTHS

103. IF UNDER 498 MONTHS

104. IF UNDER 504 MONTHS

105. IF UNDER 510 MONTHS

106. IF UNDER 516 MONTHS

107. IF UNDER 518 MONTHS

108. IF UNDER 524 MONTHS

109. IF UNDER 530 MONTHS

110. IF UNDER 536 MONTHS

111. IF UNDER 542 MONTHS

112. IF UNDER 548 MONTHS

113. IF UNDER 554 MONTHS

114. IF UNDER 560 MONTHS

115. IF UNDER 566 MONTHS

116. IF UNDER 568 MONTHS

117. IF UNDER 574 MONTHS

118. IF UNDER 580 MONTHS

119. IF UNDER 586 MONTHS

120. IF UNDER 592 MONTHS

121. IF UNDER 598 MONTHS

122. IF UNDER 604 MONTHS

123. IF UNDER 610 MONTHS

124. IF UNDER 616 MONTHS

125. IF UNDER 622 MONTHS

126. IF UNDER 628 MONTHS

127. IF UNDER 634 MONTHS

128. IF UNDER 640 MONTHS

129. IF UNDER 646 MONTHS

130. IF UNDER 652 MONTHS

131. IF UNDER 658 MONTHS

132. IF UNDER 664 MONTHS

133. IF UNDER 670 MONTHS

134. IF UNDER 676 MONTHS

135. IF UNDER 682 MONTHS

136. IF UNDER 688 MONTHS

137. IF UNDER 694 MONTHS

138. IF UNDER 698 MONTHS

139. IF UNDER 704 MONTHS

140. IF UNDER 710 MONTHS

141. IF UNDER 716 MONTHS

142. IF UNDER 722 MONTHS

143. IF UNDER 728 MONTHS

144. IF UNDER 734 MONTHS

145. IF UNDER 740 MONTHS

146. IF UNDER 746 MONTHS

147. IF UNDER 752 MONTHS

148. IF UNDER 758 MONTHS

149. IF UNDER 764 MONTHS

150. IF UNDER 770 MONTHS

151. IF UNDER 776 MONTHS

152. IF UNDER 782 MONTHS

153. IF UNDER 788 MONTHS

154. IF UNDER 794 MONTHS

155. IF UNDER 800 MONTHS

156. IF UNDER 806 MONTHS

157. IF UNDER 812 MONTHS

158. IF UNDER 818 MONTHS

159. IF UNDER 824 MONTHS

160. IF UNDER 830 MONTHS

161. IF UNDER 836 MONTHS

162. IF UNDER 842 MONTHS

163. IF UNDER 848 MONTHS

164. IF UNDER 854 MONTHS

165. IF UNDER 860 MONTHS

166. IF UNDER 866 MONTHS

167. IF UNDER 872 MONTHS

168. IF UNDER 878 MONTHS

169. IF UNDER 884 MONTHS

170. IF UNDER 890 MONTHS

171. IF UNDER 896 MONTHS

172. IF UNDER 902 MONTHS

173. IF UNDER 908 MONTHS

174. IF UNDER 914 MONTHS

175. IF UNDER 920 MONTHS

176. IF UNDER 926 MONTHS

177. IF UNDER 932 MONTHS

178. IF UNDER 940 MONTHS

179. IF UNDER 948 MONTHS

180. IF UNDER 956 MONTHS

181. IF UNDER 964 MONTHS

182. IF UNDER 972 MONTHS

183. IF UNDER 980 MONTHS

184. IF UNDER 988 MONTHS

185. IF UNDER 996 MONTHS

186. IF UNDER 1004 MONTHS

187. IF UNDER 1012 MONTHS

188. IF UNDER 1020 MONTHS

189. IF UNDER 1028 MONTHS

190. IF UNDER 1036 MONTHS

191. IF UNDER 1044 MONTHS

192. IF UNDER 1052 MONTHS

193. IF UNDER 1060 MONTHS

194. IF UNDER 1068 MONTHS

195. IF UNDER 1076 MONTHS

196. IF UNDER 1084 MONTHS

197. IF UNDER 1092 MONTHS

198. IF UNDER 1100 MONTHS

199. IF UNDER 1108 MONTHS

200. IF UNDER 1116 MONTHS

201. IF UNDER 1124 MONTHS

202. IF UNDER 1132 MONTHS

203. IF UNDER 1140 MONTHS

204. IF UNDER 1148 MONTHS

205. IF UNDER 1156 MONTHS

206. IF UNDER 1164 MONTHS

207. IF UNDER 1172 MONTHS

208. IF UNDER 1180 MONTHS

209. IF UNDER 1188 MONTHS

210. IF UNDER 1196 MONTHS

211. IF UNDER 1204 MONTHS

212. IF UNDER 1212 MONTHS

213. IF UNDER 1220 MONTHS

214. IF UNDER 1228 MONTHS

215. IF UNDER 1236 MONTHS

216. IF UNDER 1244 MONTHS

217. IF UNDER 1252 MONTHS

218. IF UNDER 1260 MONTHS

219. IF UNDER 1268 MONTHS

220. IF UNDER 1276 MONTHS

221. IF UNDER 1284 MONTHS

222. IF UNDER 1292 MONTHS

223. IF UNDER 1298 MONTHS

224. IF UNDER 1306 MONTHS

225. IF UNDER 1314 MONTHS

226. IF UNDER 1322 MONTHS

227. IF UNDER 1330 MONTHS

228. IF UNDER 1338 MONTHS

229. IF UNDER 1346 MONTHS

230. IF UNDER 1354 MONTHS

231. NAME OF CEMETERY OR CREMATORIUM

232. ADDRESS

233. LOCATION (City, town or county)

234. DATE REC'D BY REGISTRAR

235. REGISTRAR'S SIGNATURE

236. DATE

237. STAFF PAYS

238. MED. PAYS

239. ATTEND. PAYS

240. STAFF

241. MED.

242. ATTEND.

243. STAFF

244. MED.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7043

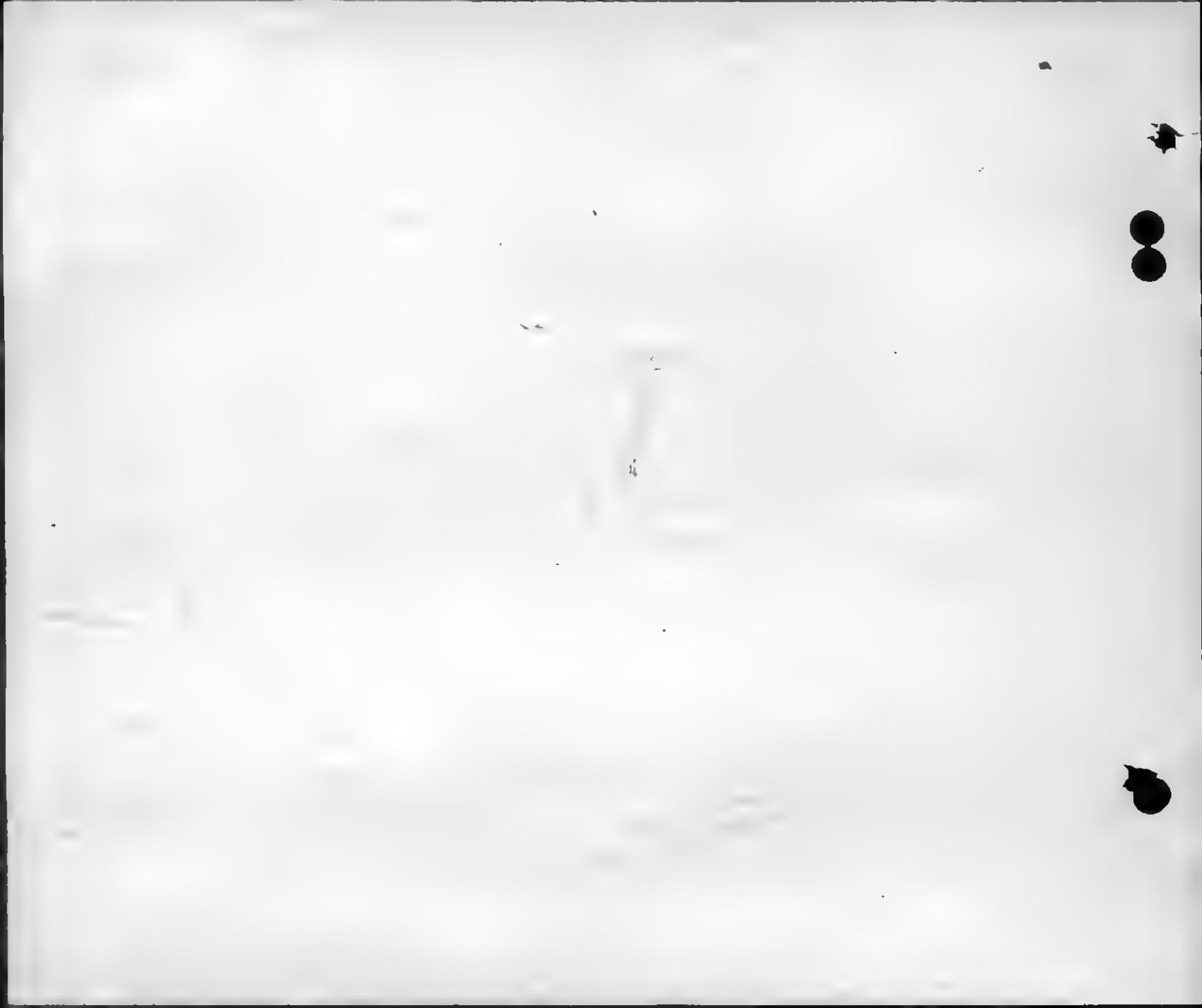
67025

Page 4

TO HOSPITAL OR CLINIC: The law requires that the death certificate be executed with **24 hours after death**.
The physician or attending physician may be retained.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE wash.		b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Montgomery</i>		d. STREET ADDRESS <i>3114 H St N.W.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kensington Gardens Sanitorium</i>				e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
3. NAME OF DECEASED (Type or print) <i>Myrtle</i>		First	Middle	Last	4. DATE OF DEATH <i>June 5 1961</i>	Month	Day	Year	
S SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 14, 1878</i>	9. AGE (In years last birthday) <i>83</i> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Name</i>		11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		
12. CITIZEN OF WHAT COUNTRY?									
13. FATHER'S NAME <i>James Bliss</i>		14. MOTHER'S MAIDEN NAME <i>Josephine Shepherd</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Relatives</i>	Address		INTERVAL BETWEEN ONSET AND DEATH <i>Same day</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4. <i>Senile dementia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Senile dementia (age 83)</i> DUE TO (c) <i>Senile dementia - 2nd</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERRING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCR BE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Coroner notified and will appear</i>							
20c. TIME OF INJURY Hour a.m. p.m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Toronto</i>	20f. (City or town) <i>Toronto</i>	(County) <i>Toronto</i>	(State) <i>Toronto</i>			
21. I certify that (I) (this hospital) attended the deceased from <i>6/5/61</i> to <i>6/5/61</i> , that (I) (we) last saw the deceased alive on <i>6/5/61</i> , and that death occurred at <i>6 A.M.</i> from the causes and on the date stated above									
22a. SIGNATURE <i>SAM ALLEN</i>		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <i>6/5/61</i>					
22c. PHYSICIAN'S NAME (Type) <i>SAM ALLEN, M.D. Kensington, Maryland</i>		22d. ADDRESS							
23a. BUR. A. (CREMATION) REMOVAL (Specify) <i>6/5/61</i>	23b. DATE THEREOF <i>6/5/61</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Forest Lawn Cemetery</i>		23d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Gerry Chase Funeral Home, Inc. D.C.</i>		ADDRESS <i>5103 Wisconsin Ave.</i>		25a. REC'D BY REGISTRAR <i>JUN 8 '61</i>	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>				



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07028

**FOR STATE
HEALTH DEPT.**

play is necessary,
and director. **Be**
for your file
Board of Health.

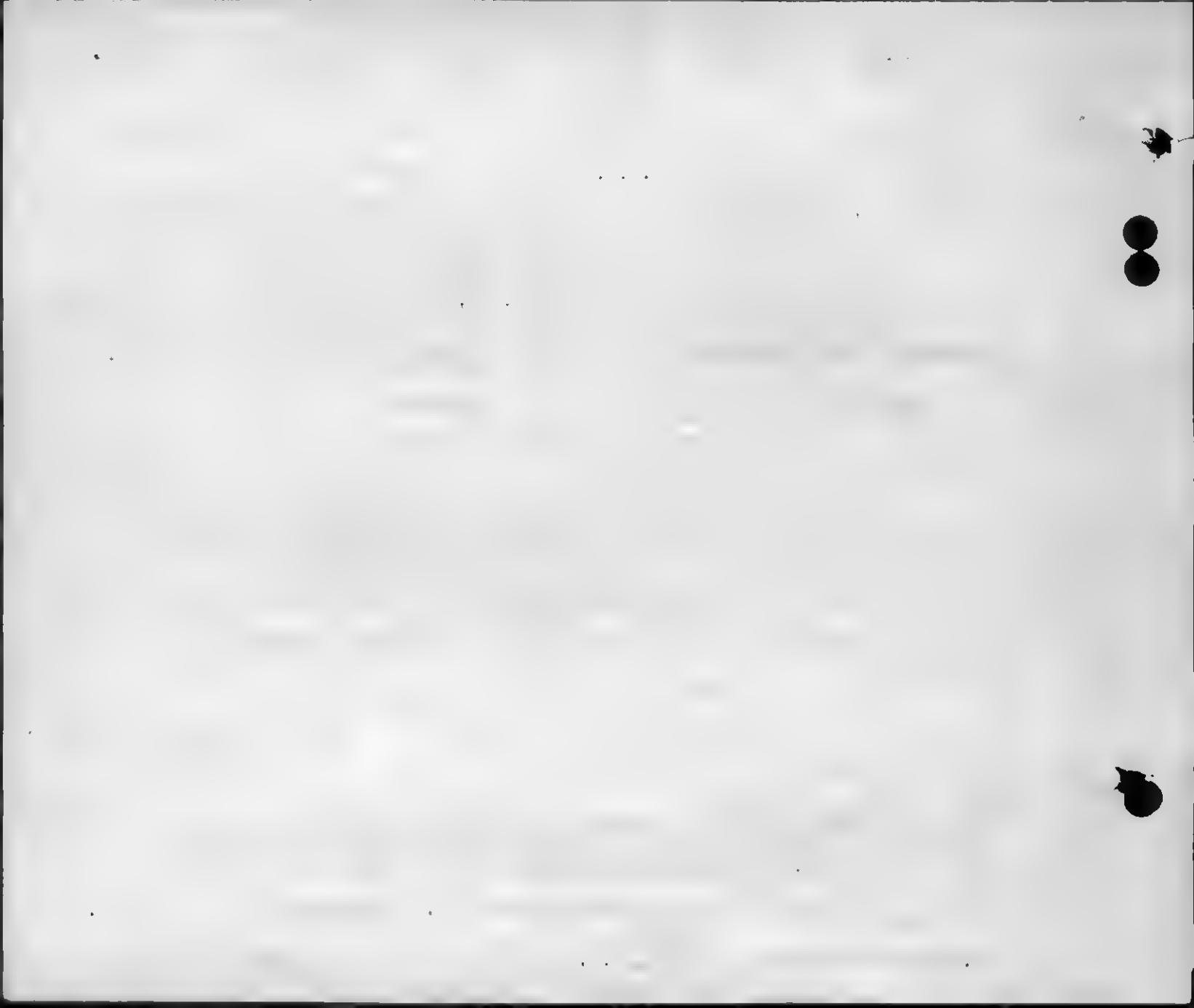
Within 24 hours after death, Give Page 1, 2, and 3 to the Coroner. Page 5 may be retained. File pages 1 and 2 with the State Coroner within 72 hours after death.

OWNER: This certificate should be executed without the word "pending" in Section 1 in Item 18 of the Medical Examiner's Office along with form 3 should be used as a burial/transit permit.

TO DEPUTY MURKIN, EXAMINE
please execute the certificate, writing
it in full. A copy should be forwarded to the
CLERK OF THE COURT, and to the
DEPARTMENT OF FUNERAL DIRECTOR. Page
or its designated agent, prior to

MEDICAL CERTIFICATION

MEDICAL CERTIFICATION		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I						19. WAS AUTOPSY PERFORMED?	
FOUND DEAD IN HER AUTO WITH SELF INFILTED BULLET WOUND THROUGH SKULL		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.									
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a.m. <input checked="" type="checkbox"/> p.m. JUNE 26 1961		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
				AUTO IN DRIVEWAY		SILVER SPRING, MONTGOMERY, MD.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
<i>Frank J. Broschart</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
FRANK J. BROSCHEART		DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		Address (Street, city, town, or county)		JUNE 26, 1961	
Burial		6/28/61		OHR KNEESETH ISRAEL CEM.		Baltimore		Ma.	
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
B. Danzansky & Sons		3501 14th St., NW Wash. D.C.		DATE JUN 28 '61		<i>Arthur S. Kline</i>			



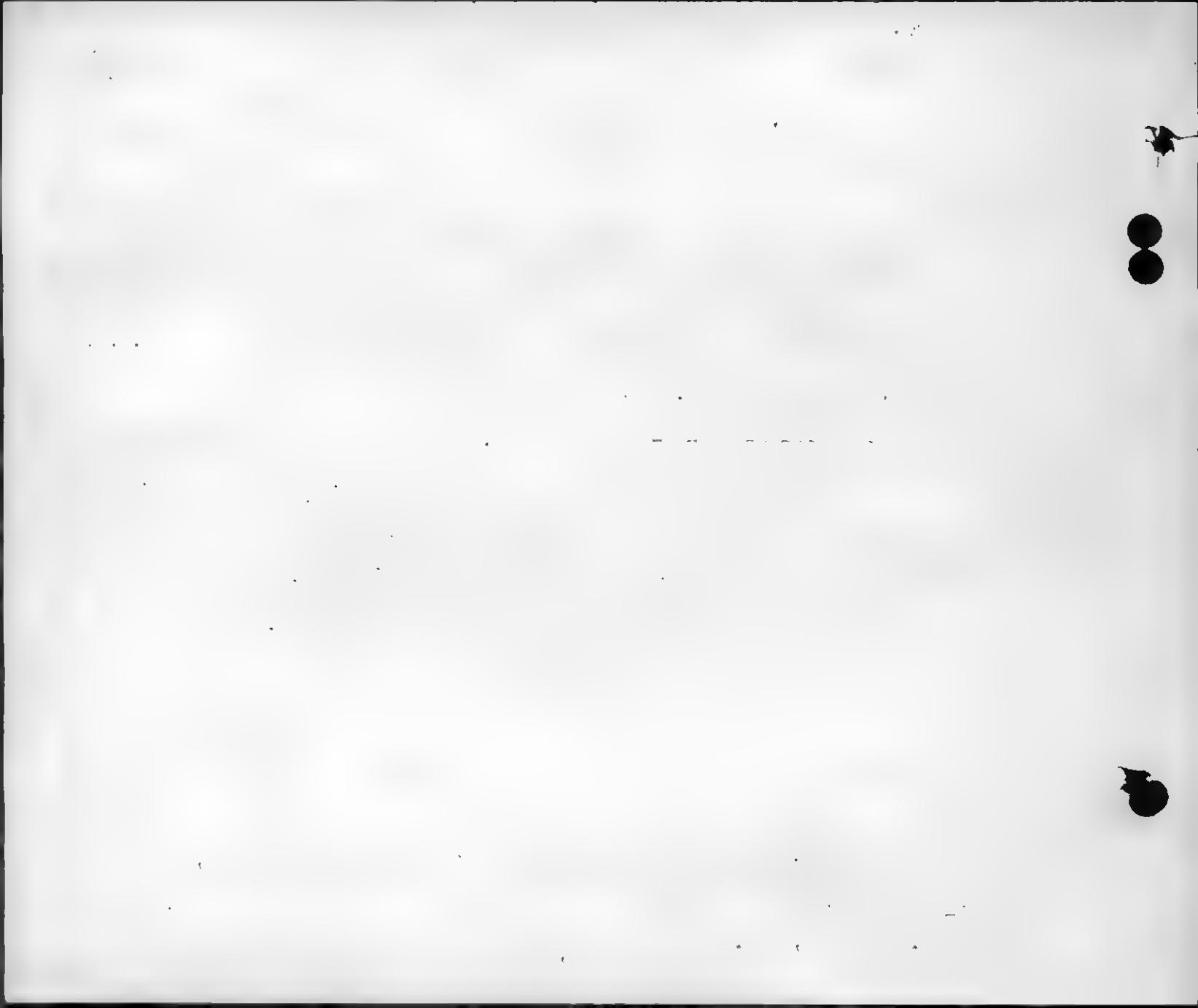
1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7029

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Montgomery		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	b. COUNTY	
RURAL and give nearest town)	14 dayd	Montgomery	
Bethesda	d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	3. NAME OF DECEASED (Type or print)	
Suburban	Milo M	First	Middle
4. DATE OF DEATH	Month	Day	Year
2806 Terrapin Road	June	15	1961
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH	9. AGE (In years lost birthday) IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. yrs Months Days Hours Min
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11/22/93 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Iron Worker	Ohio	U.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Anderson L. Van Noy		Etura Dunson Ohio	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT	
No		501-09-8972 Mary L. Nigh (daughter) same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		Sudden hours unknown	
Acute myocardial Insufficiency			
Coronary Thrombosis			
Coronary Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Diabetes Mellitus Status postoperative Amputation Right Leg.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e. (City or town) (County) (State)	
19			
21. I certify that (I) (this hospital) attended the deceased from 10-1, 1961, to 6-15, 1961, that (I) (we) last saw the deceased alive on 6-14, 1961, and that death occurred at 2 AM, from the causes and on the date stated above.			
22a. SIGNATURE		22b. DATE SIGNED	
Jason Geiger		6-15-61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
Jason Geiger		Maryland 1112 Silver Spring Avenue, Silver Spring	
23a. BURIAL, CREMATION REMOVAL (Specify)		23c. NAME OF CEMETERY OR CREMATORIAL TOWNSHIP	
Burial-Transit 6/16/61		Kingsmill Cemetery	
23d. LOCATION (City, town, or county) (State)		London Madison County Ohio	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. ADDRESS	
Warner E. Pimphrey, Inc. 8434 Georgia Avenue		Silver Spring, Maryland	
Raymond A. Licka		25a. REC'D BY REGISTRAR DATE JUN 19 '61	
		25b. REGISTRAR'S SIGNATURE	
		Oliver S. Kraus	

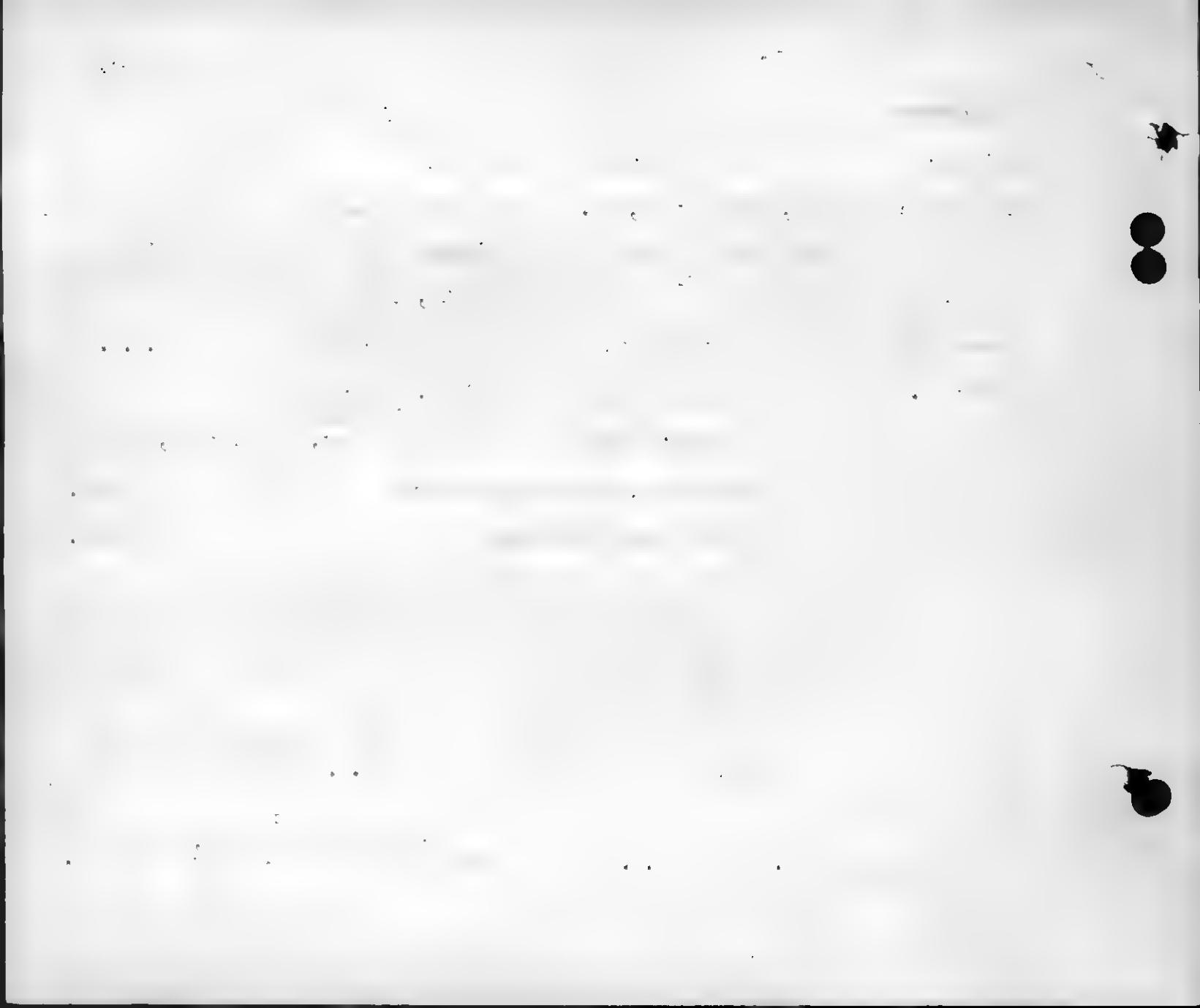


**HOSPITAL OR
HOLDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 74 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bluefield		d. STREET ADDRESS 226 Larch Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Charlotte Louise Vincent		First	Middle	Last	4. DATE OF DEATH June 19 1961	Month	Day	Year
S SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH October 28, 1915	9. AGE (In years (at birthday) yrs 45	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Clerk		10b. KIND OF BUSINESS OR INDUSTRY Commercial		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Robert H. Gilpin				14. MOTHER'S MAIDEN NAME Julia E. Hager				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT The Medical Record Address Unascertainable The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO (b) Candidations, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		Increased intracranial pressure		INTERVAL BETWEEN ONSET AND DEATH 2 mos.		
193.9								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from April 6 1961 to June 19 1961, that (I) (we) last saw the deceased alive on June 19 1961, and that death occurred at 9:04 P.M. from the causes and on the date stated above.								
22a. SIGNATURE <i>Philip J. Ferris, M.D.</i>		ATTENDING PHYS <input type="checkbox"/>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS <input checked="" type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) PHILIP J. FERRIS, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.				22e. DATE SIGNED 6/20/61		
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 6/22/61		23c. NAME OF CEMETERY OR CREMATORIAL Roselawn Cemetery		23d. LOCATION (City, town, or county) Princeton, W. Virginia		
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		ADDRESS		25a. REC'D BY REGISTRAR DATE JUN 22 '61		25b. REGISTRAR'S SIGNATURE Lorraine S. Kraus		



HOSPITAL OR HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

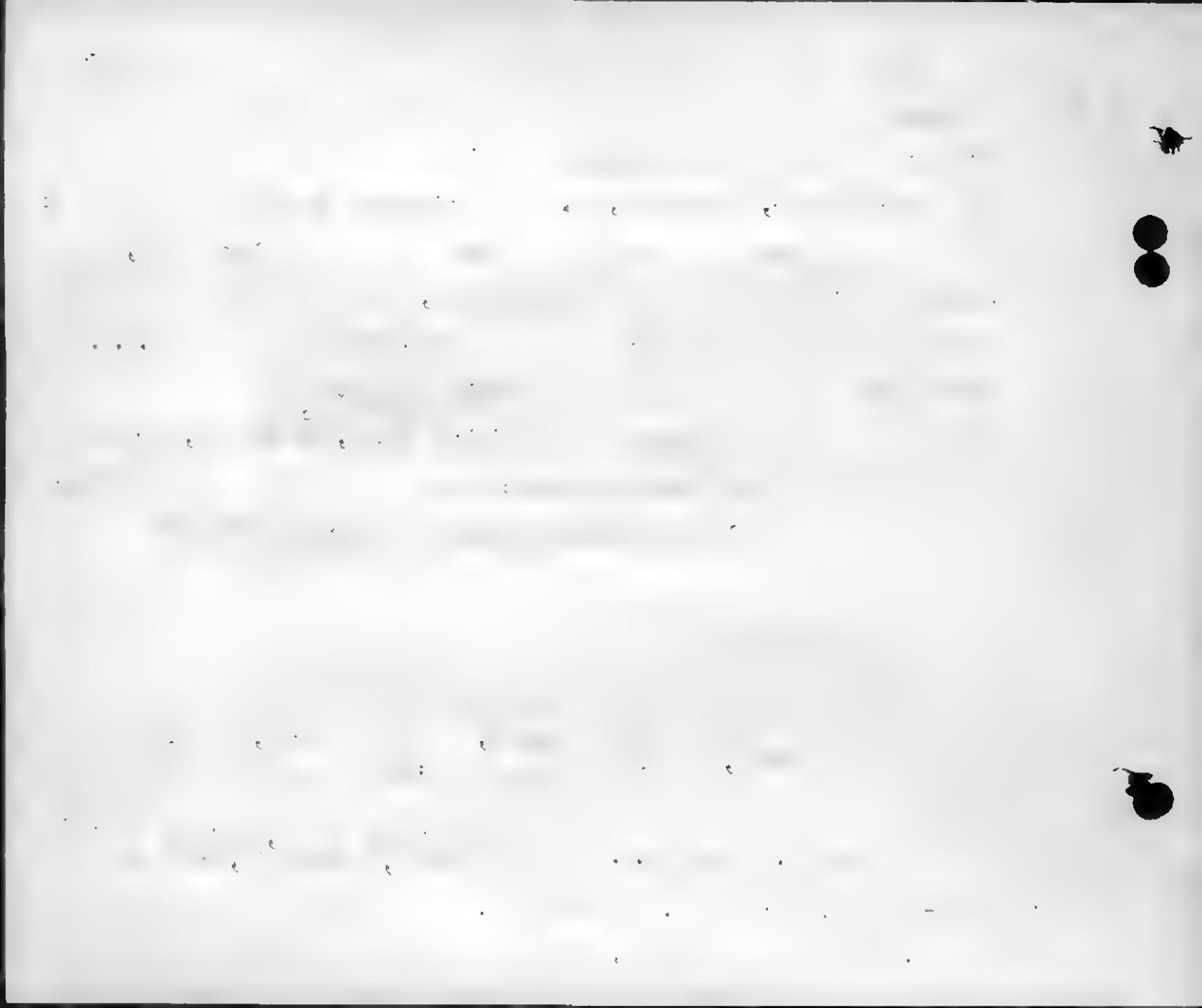
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2044

07031

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE New Jersey		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lodi			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. STREET ADDRESS 56 Christopher Street		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mary	Middle Ann	Last Voto	4. DATE OF DEATH January 29, 1955	Month June	Day 8,	Year 1961
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 29, 1955		9. AGE (In years last birthday) 6 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Voto				14. MOTHER'S MAIDEN NAME Matilda Bauagnoli			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Post operative cardiac arrest INTERVAL BETWEEN ONSET AND DEATH 11 hours							
754		DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.	DUE TO (c)	Following complete correction of tetralogy of Fallot			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 20d. INJURY OCCURRED p. m. 19 While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) June 4, 1961 20f. (City or town) June 8, 1961 (County) 61 (State) 61	
21. I certify that (I) (this hospital) attended the deceased from June 5, 1961 to June 8, 1961 , that (I) (we) last saw the deceased alive on June 5, 1961 , and that death occurred at 5:30 AM from the causes and on the date stated above							
22a. SIGNATURE <i>James L. Talbert</i>		M.D. <input type="checkbox"/> ATTENDING PHYS <input type="checkbox"/> <i>James L. Talbert</i>	MED. DIRECTOR <input type="checkbox"/> <i>James L. Talbert</i>	STAFF PHYS <input checked="" type="checkbox"/> <i>James L. Talbert</i>	22b. DATE SIGNED 6/8/61		
22c. PHYSICIAN'S NAME (Type) JAMES L. TALBERT, M.D.		22d. PLACE OF DEATH The Clinical Center, National Institutes of Health, Bethesda 14, Maryland					
23a. BURIAL, CREMATION, REMOVALS (Specify) Burial-trans		23b. DATE THEREOF 6/8/1961		23c. NAME OF CEMETERY OR CREMATORIUM St. Nicholas Cem.		23d. LOCATION (City, town, or county) Lodi (State) New Jersey	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE JUN 9 '61	25b. REG STRAR'S SIGNATURE <i>Robert A. Pumphrey</i>



M TO HOSPITAL OR
may be removed to hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

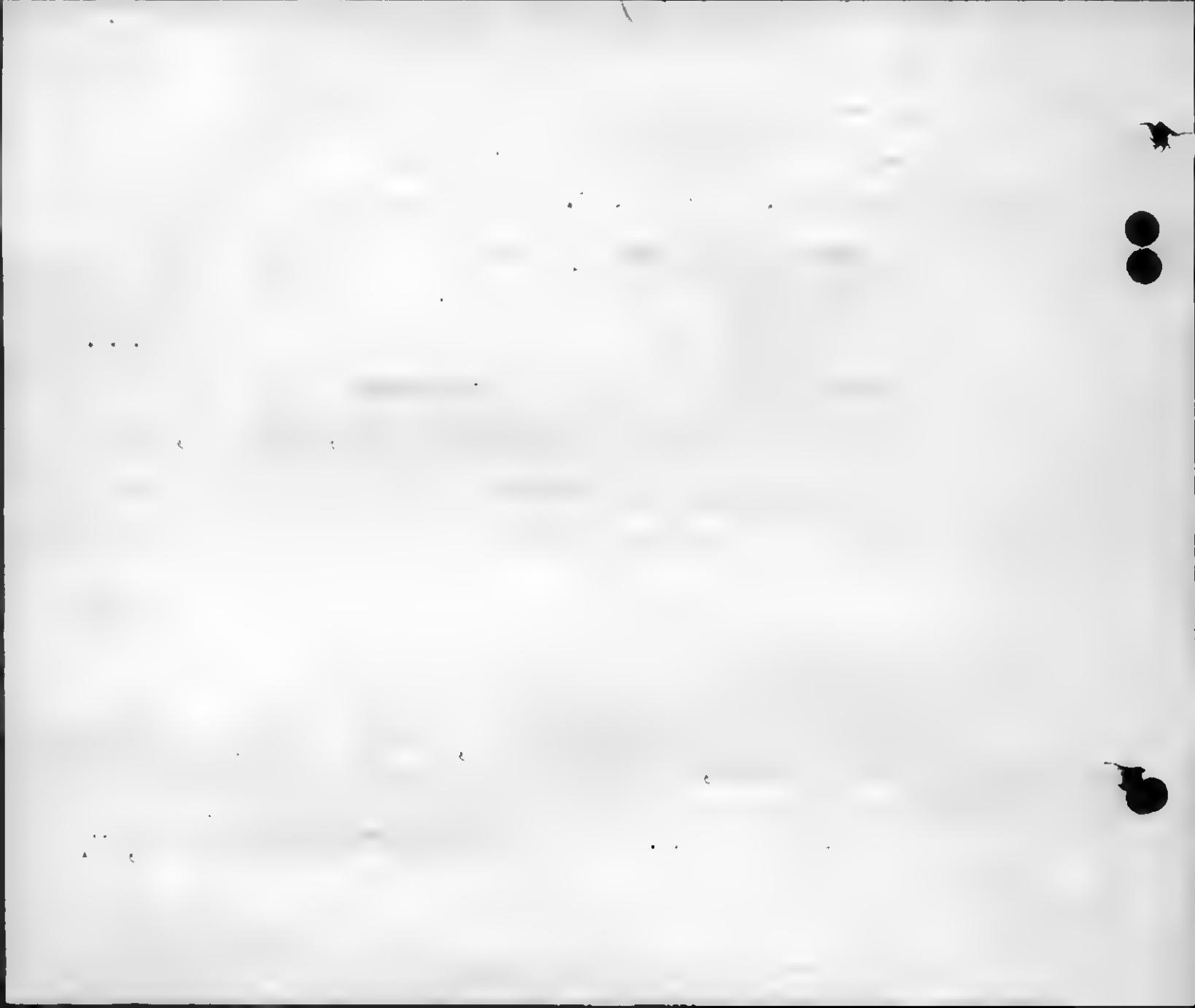
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7045 07032

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 12 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cape May		d. STREET ADDRESS 1127 Indiana Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Sherry	Middle Anne	Last Walden	4. DATE OF DEATH	Month June	Day 23	Year 19 61
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1954	9. AGE (in years last birthday) 6 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Hours 0	IF UNDER 24 HRS Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) California		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stanley Walden				14. MOTHER'S MAIDEN NAME Joan Watton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type or unknown) NO		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Records Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive Heart Failure INTERVAL BETWEEN ONSET AND DEATH hrs.							
DUE TO 154.0							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Tetralogy of Fallot (c) Congenital							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 11, 1961 to June 23, 1961 , that (I) (we) last saw the deceased alive on June 23, 1961 , and that death occurred at 10:00 PM the causes and on the date stated above.							
22a. SIGNATURE O. W. McBride				22b. DATE SIGNED 6-21-61			
22c. PHYSICIAN'S NAME (Type) O. W. McBride M.D.		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22d. ADDRESS National Institutes Of Health The Clinical Center, Bethesda 14, Md.			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial 6-27-61		23b. DATE THEREOF 6-27-61		23c. NAME OF CEMETERY OR CREMATORIAL Fairview Cemetery Cape May Court House N.J.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. Riverdale Md.		ADDRESS W. W. Chambers Co. Riverdale Md.		25a. REC'D BY REGISTRAR DATE JUN 27 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death. Page 4 is to be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 24 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

7046

CERTIFICATE OF DEATH

07033

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
Montgomery		b. STATE D.C.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
Takoma Park Md		Washington	
c. LENGTH OF STAY IN MD		d. STREET ADDRESS	
24 days		3133 Conn. Ave. N.W.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM?	
Washington Sanatorium & Hospital		YES NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		f. DATE OF DEATH	
Elinor Gardiner Walker		June 14 1961	
4. SEX		g. AGE (In years last birthday)	
Female		50 yrs	
h. COLOR OR RACE		h. IF UNDER 1 YEAR Months Days Hours M.n.	
White			
i. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		i. IF UNDER 24 HRS.	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Months Days Hours M.n.	
j. DATE OF BIRTH		j. IF UNDER 24 HRS.	
Feb. 1, 1881		Hours M.n.	
k. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		l. BIRTHPLACE (County & State, or foreign country)	
Retired Gov't Employee		D.C.	
m. FATHER'S NAME		m. MOTHER'S MAIDEN NAME	
William J. Walker		Adelaide Morris	
n. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		o. SOCIAL SECURITY NO. 17 INFORMANT	
no		Address	
p. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		q. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Old Hospital Record	
442 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		Chronic heart disease	
DUE TO (b) DUE TO (c)		Hypertension - Arteriosclerosis and Diabetes with multiple infarcts	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)		Injury no accident	
r. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		s. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
t. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		u. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) v. (City or town) (County) (State)	
20c. 19		20d. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>July 24 1959</u> to <u>July 26 1961</u> , that (I) (we) last saw the deceased alive on <u>July 26 1961</u> , and that death occurred at <u>8:22 A.M.</u> from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
Frank L. Williamson		MD ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23c. NAME OF CEMETERY OR CREMATORIUM	
Cremation 6/16/61		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE	
John Hines Co. 2901 14th St. N.W.		REC'D BY REGISTRAR JUN 15 '61	
VR A15 (4) 15M 9/60		Arthur S. Kraus	

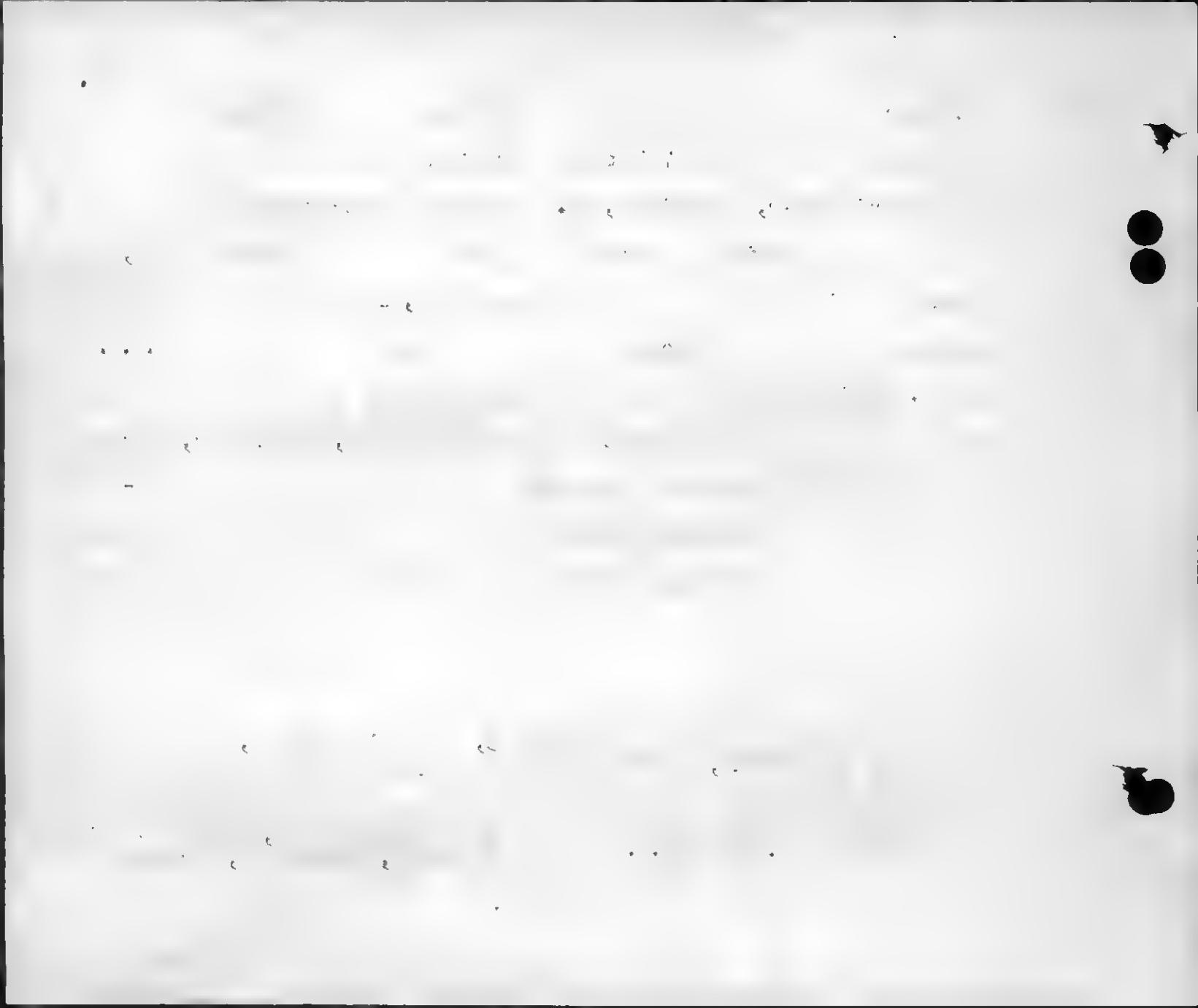


1 TO HOSPITAL OR
may be retained
TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7047		07034	
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution or Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield	
3. NAME OF DECEASED (Type or print) Bertie Mae Ward		4. DATE OF DEATH Month June Day 10 , Year 1961	
S. SEX Female COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH December 27, 1894		9. AGE (In years lost birthday) 66 yrs. IF UNDER 1 YEAR Months 66 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John T. Riggan		14. MOTHER'S MAIDEN NAME Louise Lawson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO Unavailable	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Myasthenia Gravis DUE TO (c) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 1 - 2 Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While at work	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) June 3, 1961 to June 10, 1961 (County) June 10, 1961 (State)	
21. I certify that (I) (this hospital) attended the deceased from June 10, 1961 to June 10, 1961 , that (I) (we) last saw the deceased alive on June 10, 1961 , and that death occurred at 5:00 AM from the causes and on the date stated above.			
22a. SIGNATURE Charles A. Payne, M.D.		22b. DATE SIGNED 6/10/61	
22c. PHYSICIAN'S NAME (Type) Charles A. Payne M.D.		22d. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-18-61	
23c. NAME OF CEMETERY OR CREMATORIALy Crisfield Md.		23d. LOCATION (City, town, or county) Crisfield Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Lee F. Tamm, Home Hash, D.C.		ADDRESS Clifford S. Tamm	
		25a. REC'D BY REGISTRAR JUN 13 '61	
		25b. REGISTRAR'S SIGNATURE Clifford S. Tamm	



TO HOSPITAL OR
 may be retained
 TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director.
 Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

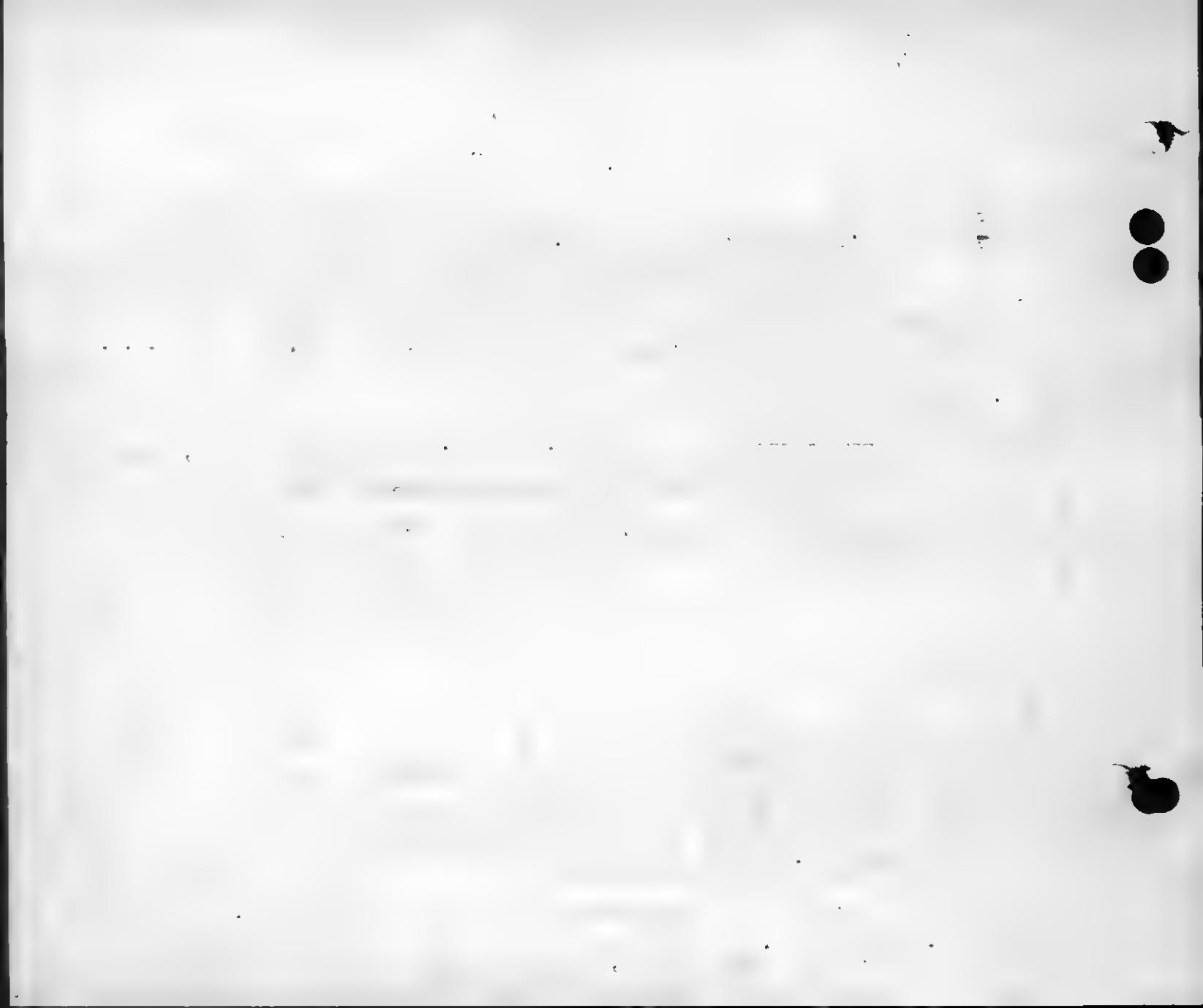
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7048

07035

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb eleven years		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 415 Penwood Road						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
						d. STREET ADDRESS 415 Penwood Road			
3. NAME OF DECEASED (Type or print)		First ANNE	Middle MARIE	Last WARNER	4. DATE OF DEATH 6 15 1961		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/20/07		9. AGE (In years last birthday) 53 yrs		IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS Days 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) New York, New York.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Mr. Thomas Kennedy		14. MOTHER'S MAIDEN NAME Ireland Bridget Unknown Ireland							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Zolie V. Warner		Address 415 Penwood Road Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 416X		DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Acute Congestive HEART FAILURE		INTERVAL BETWEEN ONSET AND DEATH Minutes			
		DUE TO (c)		Chronic Rheumatic HEART DISEASE					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (his hospital) attended the deceased from JUNE 1960 to JUNE 1961 , that (I) (we) last saw the deceased alive on APRIL 1961 , and that death occurred at 415 Penwood Road , from the causes and on the date stated above.									
22a. SIGNATURE Bernard A. Fitzgerald		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b. DATE SIGNED 6-15-61			
22c. PHYSICIAN'S NAME (Type) Bernard A. Fitzgerald		22d. ADDRESS 217 UNIVERSITY Blvd E. S.S. Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/19/61		23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery		23d. LOCATION (City, town, or county) (State) Montgomery Co. Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Zwick		ADDRESS 8434 Georgia Avenue Silver Spring, Maryland		25a. REC'D BY REGISTRAR JUN 20 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 07036

Page 4 of 24 hours after death by the funeral director.
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the funeral director.
 Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Md		b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rivendale		d. STREET ADDRESS 5801 Taylor Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash San & Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Edward		First H.	Middle Watts	Last 	4. DATE OF DEATH June 2, 1961	Month June	Day 2	Year 1961
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH August 28th 1910	9. AGE (in years last birthday) 50	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Hours 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kentucky		12 CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Edward Watts		14. MOTHER'S MAIDEN NAME Martha Duval						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. W 111-11-2		17. INFORMANT Blanche Watts 5801 Taylor Rd, Riverdale, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				<i>Myocardial clapsation</i>		INTERVAL BETWEEN ONSET AND DEATH 30 min		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)				<i>Coronary artery disease</i>		1 year		
DUE TO (c)				<i>Arteriosclerosis</i>		5 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. p. n. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 5-26-61 , 19, to 6-2-61 , 19, that I last saw the deceased alive on 5-31-61 , 19, and that death occurred on 6-2-61 , 19, M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE <i>John P. Clum</i>		M.D.		<i>Rivendale Md 6-2-61</i>		DATE SIGNED		
PHYSICIAN'S NAME (Type) John P. Clum								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 6-1961		22c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Oval		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. F. Costello</i>		ADDRESS <i>1722 No Capri</i>		24a. REC'D BY REGISTRAR DATE JUN 5 '61		24b. REGISTRAR'S SIGNATURE <i>James S. Thorne</i>		

جبل العذارى

جبل العذارى ١٦٢ كم من المدائن
جبل العذارى ٤٣ كم من مدائن صالح

X 1
FOR STATE
HEALTH DEPT.

Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, separation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7050

67037

1. PLACE OF DEATH
e. COUNTY

Montgomery
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

Silver Spring

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

1523 Grace Church Road

First

MARYLAND

c. LENGTH OF STAY IN IB

10 yrs.

2. USUAL RESIDENCE (Where deceased lived, if institution, resided before admission)
e. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

Silver Spring

d. STREET ADDRESS

3. NAME OF
DECEASED
(Type or print)

Phyllis H.

Werder

5. SEX

6. COLOR OR RACE

Female

White

100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

5/17/22

9. AGE (In years last birthday)

Last June 7,

Month

Year

39 yrs.

Month

Days

Hours

Min.

13. FATHER'S NAME

Thomas F. Hawley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

Yes WWI

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

114X DUE TO
Conditions, if any, which
gave rise to immediate cause
(b)

DUE TO
cause listed. (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

20e. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING

CAUSE OF DEATH.

20e. TIME OF INJURY Month, Day, Year

Hour e.m. 5 - 6 1/7/61

p.m. 19

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Hanging self with clothes line in basement.

20d. INJURY OCCURRED

While at work

Not While at work

at work

20e. PLACE OF INJURY (Home, farm, 20f. (City or town)

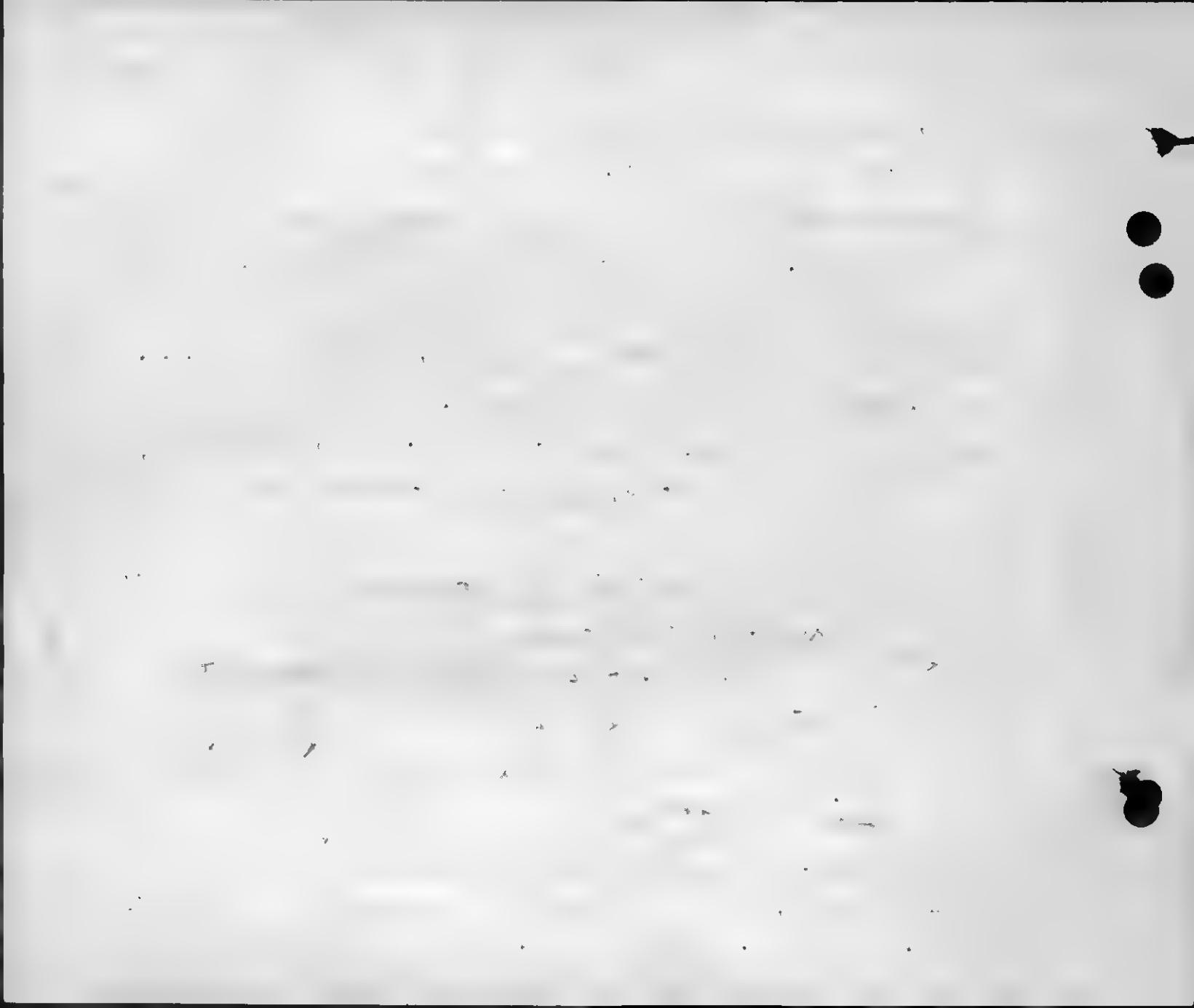
factory, street, office bldg., etc.)

factory, street, office bldg., etc.)

20e. PLACE OF INJURY (Home, farm, 20f. (City or town)

factory, street, office bldg., etc.)

factory, street, office bldg., etc.)</



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be countersigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7051

CERTIFICATE OF DEATH

07038

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda (Rural)

c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

U. S. Naval Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Helen

Louise

5. SEX

Female

6. COLOR OR RACE

Caucasian

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

Maryland

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Patuxent River

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?

YES NO

37 days

c. LENGTH OF STAY IN lb

773B MEMO Naval Air Station

Last

4. DATE
OF
DEATH

Month

Day

Year

June

7

19 61

5-30-28

8. DATE OF BIRTH

9. AGE (in years) IF UNDER 1 YEAR
last birthday

33

Yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

1Db. KIND OF BUSINESS OR INDUSTRY

11. BIRTH-PL. ACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Vernon L. FLEMINGS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give rank or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

14. MOTHER'S MAIDEN NAME

Marietta M. BENNETT

Address

(H) John W. White, same as #2 above

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

411

aortic insufficiency

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

rheumatic heart disease

(c)

INTERVAL BETWEEN
ONSET AND DEATH

20 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED

While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (X) (this hospital) attended the deceased from May 1, 1961 to June 7, 1961, that (X) (we) last saw the deceased alive on June 7, 1961, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE

Bruce Harold Rice

M.D.

ATTEND NG
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED
6-8-61

22c. PHYSICIAN'S
NAME (Type)

Bruce Harold RICE, LT, MC, USN

U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial-Shipment 6-9-61

23c. NAME OF CEMETERY OR CREMATORI

Oak Grove Cemetery

23d. LOCATION (City, town or county)

(State)

Bath

Maine

24. FUNERAL DIRECTOR'S SIGNATURE

R. A. Pumphrey Funeral Home, Bethesda, Md.

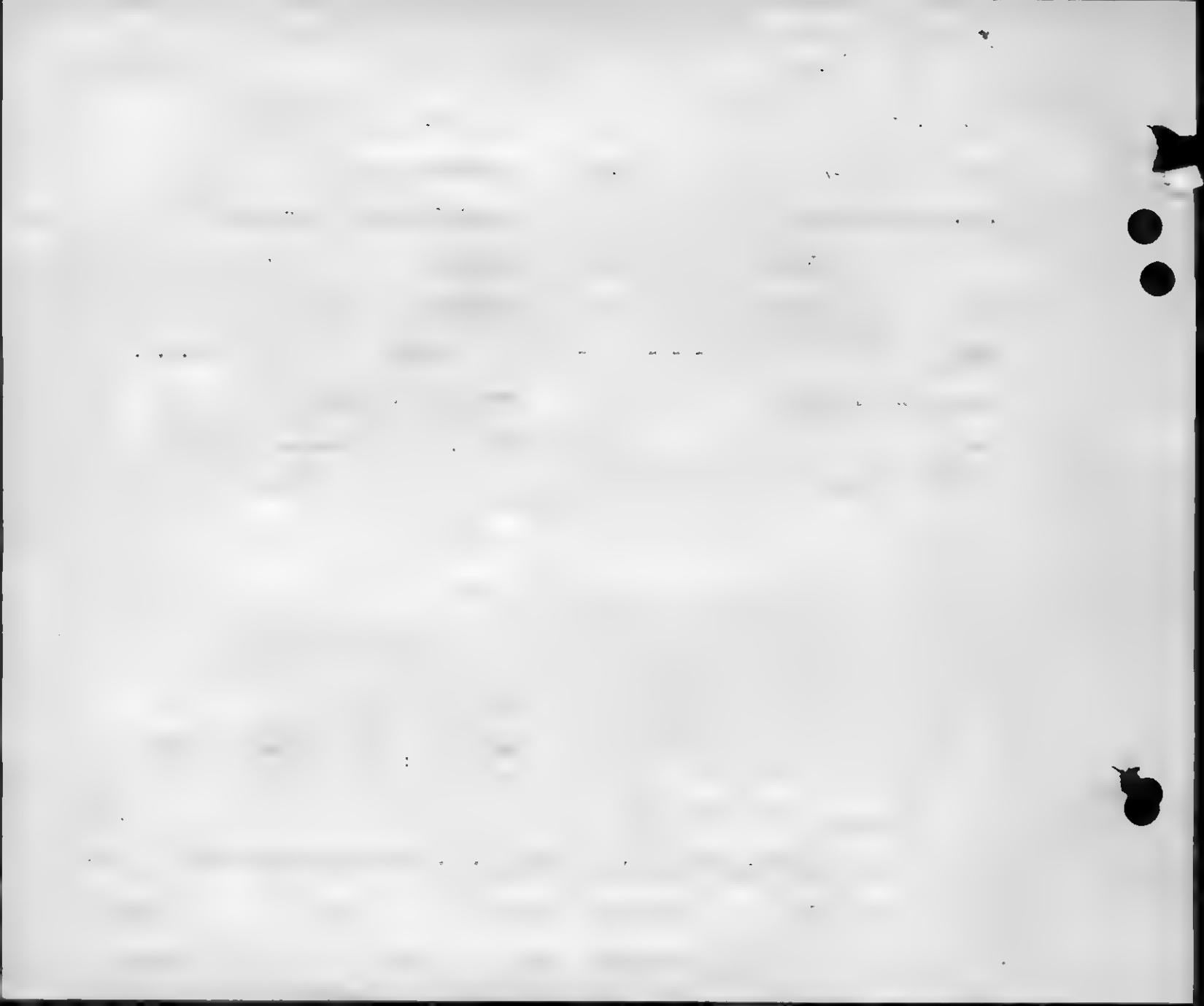
ADDRESS

25a. REC'D BY REGISTRAR

DATE JUN 9 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Thorne



HOSPITAL OR HOMING PHYSICIAN: The law requires that the death certificate be executed
may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7052

07039

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) c. STATE	
<i>Montgomery</i>		<i>Chesapeake</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. LENGTH OF STAY IN 1b <i>10 days</i>	
<i>LaRoma Park</i>		e. STREET ADDRESS <i>25 Holt Place</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>Washington Sanitarium & Hospital</i>			
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Ethel</i>		<i>Lee</i>	<i>Williams</i>
4. DATE OF DEATH		Month	Day Year
<i>6-7-61</i>		<i>6</i>	<i>30 1961</i>
5. SEX		6. COLOR OR RACE	
<i>Female</i>		<i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
<i>Never married</i>		<i>6-7-07</i>	
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
<i>54 yrs</i>		Months	Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Housewife</i>		<i>Tennessee</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Tennessee</i>		<i>USA</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>J. Henry Chesney</i>		<i>Cordie Crawford</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<i>No</i>		<i>17. INFORMANT</i>	
		<i>Patient's Chart</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>7 years.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		<i>Rheumatic heart disease</i>	
DUE TO (b)		<i>Congestive Cardiac Failure</i>	
DUE TO (c)		<i>Chronic Glomerulo - Nephritis</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>April 1961</i> to <i>June 30 1961</i> , that (I) (we) last saw the deceased alive on <i>June 30 1961</i> , and that death occurred at <i>615 M</i> , from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE <i>Robert A. Hare</i>		22b. DATE SIGNED <i>6/30/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>Robert A. HARE</i>		22d. ADDRESS <i>7600 Carroll Ave. T.P. Md.</i>	
23a. BUR. A. CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>July 4, 1961</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>New Hope Cemetery</i>		23d. LOCATION (City, town, or county) <i>Knoxville</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. Adams Staley</i>		25a. REC'D BY REGISTRAR DATE, <i>Jul 3 '61</i>	
ADDRESS <i>254 Carroll St NW, DC</i>		25b. REGISTRAR'S SIGNATURE <i>Charles E. Krause</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the funeral director, or attending physician, if either has been signed by the attending physician and completely filled in. If either has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

X
M

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY MONTGOMERY				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				b. COUNTY MONTGOMERY							
c. LENGTH OF STAY IN 1b 18 YEARS				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 728 EASLEY STREET				d. STREET ADDRESS 728 EASLEY STREET							
3. NAME OF DECEASED (Type or print) JUDITH E. WILLIS				4. DATE OF DEATH Month JUNE				Day Year 18 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 10, 1881		9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR Months Days Hours Min	
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY NONE				11. BIRTHPLACE (State or foreign country) PORTSMOUTH, NO. CAR.			
13. FATHER'S NAME ALONZO				14. MOTHER'S MAIDEN NAME CORA NEWTON				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) NO.				16. SOCIAL SECURITY NO. NONE				17. INFORMANT INEZ A. BAILEY, 728 EASLEY ST., SILVER SPRING, MD.			
Address INTERVAL BETWEEN ONSET AND DEATH 2 DAYS											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY CONGESTION DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ARTERIOSCLEROTIC HEART DISEASE 5 YEARS DUE TO (c) GENERALIZED ARTERIOSCLEROSIS											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CEREBRO VASCULAR ACCIDENT (Feb. 27, 1961).											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. — p. m. —				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 15, 1961 , to June 18, 1961 , that (I) (we) last saw the deceased alive on June 10, 1961 , and that death occurred at 4 AM , from the causes and on the date stated above											
22a. PHYSICIAN'S NAME (Type) BELDEN R. REAP, M.D.				22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. ADDRESS 11602 GRANDVIEW AVE., SILVER SPRING, MARYLAND			
22d. LOCATION (City, town, or county) ARLINGTON NAT'L CEM. GREENSBORO, VIRGINIA								22e. DATE SIGNED June 18, 1961			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 6/21/61				23c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NAT'L CEM. GREENSBORO, VIRGINIA			
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co-1400 CHAMBERS ST NW WASH. D.C.				ADDRESS				25a. REC'D BY REGISTRAR DATE JUN 21 '61		25b. REGISTRAR'S SIGNATURE Charles S. Evans	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M
C
C

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN lb 9 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) 59 ROCKVILLE d. STREET ADDRESS 263 E EAST MONTGOMERY AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) PATRICIA			First PATRICIA Middle ELAINE Last WILLOUGHBY			4. DATE OF DEATH JUNE 7, 1961			Month JUNE Day 7 Year 1961				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH MAY 29, 1961		9. AGE (In years lost birthday) 9 DAYS		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS Months 9 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY INFANT				11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILBERT HAROLD WILLOUGHBY						14. MOTHER'S MAIDEN NAME ZELMA SHACKELFURD							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BILATERAL BRONCHO-PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PREMATURITY (3-7g) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)												INTERVAL BETWEEN ONSET AND DEATH 9 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) Gaithersburg (County) Maryland (State) Maryland				
21. I certify that (I) (this hospital) attended the deceased from 5-29-61 , 19, to 6-7- , 1961, that (I) (we) last saw the deceased alive on 6-7- 1961 , and that death occurred at 6:23 P.M. From the causes and on the date stated above													
22a. SIGNATURE 						22b. DATE SIGNED 6/8/61							
22c. PHYSICIAN'S NAME (Type) C. H. LIGON, M. D.						22d. ADDRESS SANDY SPRING, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/9/61		23c. NAME OF CEMETERY OR CREMATORIAL Forest Oak				23d. LOCATION (City, town, or county) (State) Gaithersburg, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home						ADDRESS 1331 E. Montg. Ave. Rockville, Md.		25a. REC'D BY REGISTRAR DATE 6-12-61		25b. REGISTRAR'S SIGNATURE 			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7055

CERTIFICATE OF DEATH

07042

1. PLACE OF DEATH
a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda (Rural)

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

U. S. Naval Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Robert

Elmore

5. SEX

6. COLOR OR RACE

Male

Caucasian

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Officer

13. FATHER'S NAME

John Carl WILSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and date of service)

Yes 1928 to 1958

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Adenocarcinoma, liver, with metastasis

156.1
Conditions, if any, which
gave rise to immediate causa
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

MEDICAL CERTIFICATION

2Da. ACCIDENT WAS UNDERLYING 2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m.2Dd. INJURY OCCURRED
While at work Not While at work

2Dc. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2Df. (City or town)

(County)

(State)

21. I certify that (this hospital) attended the deceased from May 9, 1961 to June 11, 1961, that (we) last saw the deceased alive on June 11, 1961, and that death occurred at 8:50 AM, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

J. E. STITCHER, LT, MC, USN

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. 22b. DATE SIGNED
6-12-61

22d. ADDRESS

U. S. Naval Hospital, Bethesda, Md.

23e. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIAL

23d. LOCATION (City, town or county)

(State)

Burial

6-14-61

Arlington National

Arlington

Virginia

24 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS Arlington, Va.
Arlington Funeral Home, 3901 N. Fairfax Dr.

25a. REC'D BY REGISTRAR DATE JUN 15 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Krause

hours after

M

051

I



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

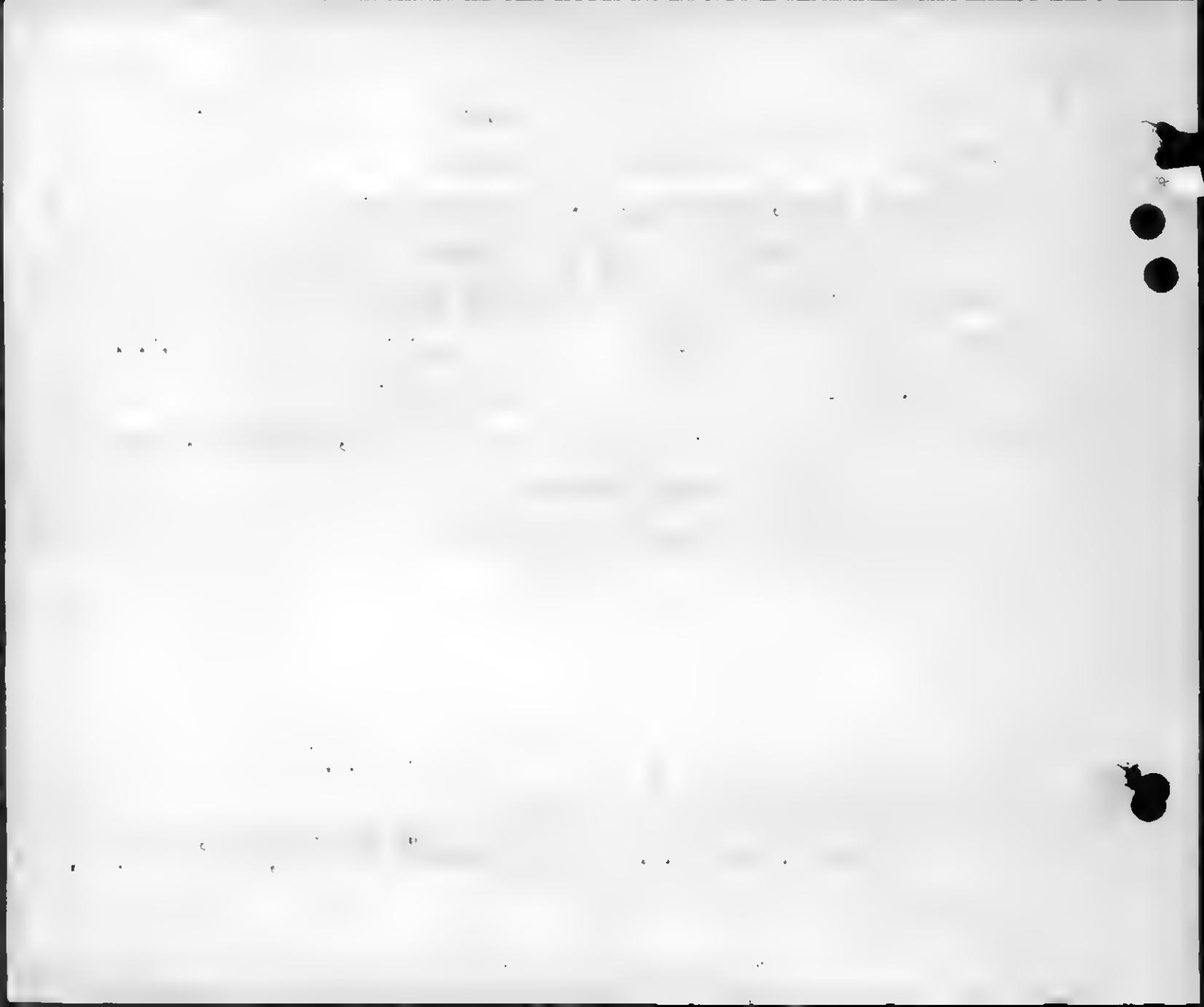
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07043

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 25 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Winchester		d. STREET ADDRESS 610 Hillman Drive	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Marty	Middle Ann	Last Windle	4. DATE OF DEATH	Month June	Day 5	Year 1961
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	b. DATE OF BIRTH January 24, 1956	9. AGE (In years last birthday) 5 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Norman E. Windle				14. MOTHER'S MAIDEN NAME June Marshall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>1 7 X</i> Cardiac arrhythmia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Metastatic Wilms Tumor DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 1 week							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 11, 1961 to June 5, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 5, 1961 , and that death occurred at 9:10 p.m. From the causes and on the date stated above							
22a. SIGNATURE <i>Jerome B. Block</i>				M.D.	ATTENDING PHYS <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) JEROME B. BLOCK, M.D.				22b. DATE 6/6/61			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 6-9-61		23c. NAME OF CEMETERY OR CREMATORIUM Lebanon Church Cem.		23d. LOCATION (City, town, or county) Lebanon Church (State) VA	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR DATE JUN 8 '61		25b. REGISTRAR'S SIGNATURE Charles S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7057

07044

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

174

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MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 17 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas W. Waltz		First	Middle
4. SEX Male		Last	5. DATE OF DEATH June 20 1961
6. COLOR OR RACE White		Month	Day
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Year	Year
8. DATE OF BIRTH 11/21/73		9. AGE (In years at birthdate) 87 yrs.	10. IF UNDER 1 YEAR Months Dey Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		11. BIRTHPLACE (County & State, or foreign country) Virginia	
10b. KIND OF BUSINESS OR INDUSTRY Private		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles E. Waltz		14. MOTHER'S MAIDEN NAME Mammie Landown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 17. INFORMANT 578-67-445 Grace DeGroat Address 15 Erickson, Cabin John, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure & Emphysema Conditions, if any, which gave rise to immediate cause (b) Prostateism & Kidney Disease and (c) Fr. of rt. hip		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 4, 1961 to June 20, 1961, that (I) (we) last saw the deceased alive on June 19, 1961, and that death occurred at 5:30 PM, from the causes and on the date stated above.		22b. DATE SIGNED	
22e. SIGNATURE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 8106 Maple Ridge Rd, Bethesda, Md.	
23e. BURIAL, CREMATION REMOVAL (Specify) Burial 6/23/61		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill	
24. FUNERAL DIRECTOR'S SIGNATURE		23d. LOCATION (City, town or county) (State) Beltsville, Md.	
ADDRESS 1817 Georgia		25e. REC'D BY REGISTRAR	
Deal Funeral Home, Inc., D.C.		25b. REGISTRAR'S SIGNATURE	
DATE JUN 23 '61		Ching S. Thomas	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

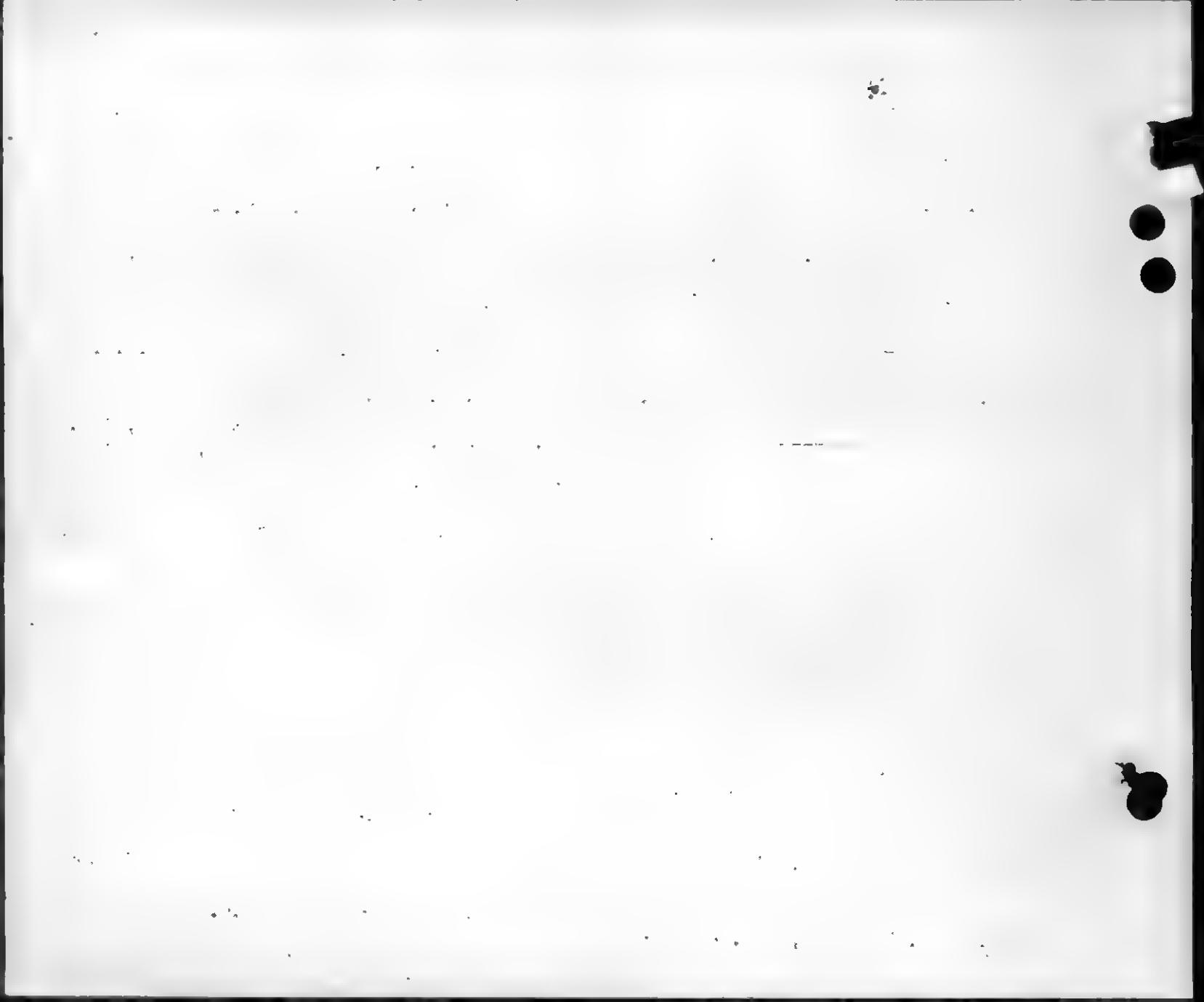
CERTIFICATE OF DEATH

Reg. Dist. No.

07045

M

PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 8 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 8712 Colesville Road, Apt. # 408		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mrs. Bartlings Nursing Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Mrs. Ella A. Wood		First	Middle	Lost	4. DATE OF DEATH June	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9/14/73	9. AGE (in years lost birthday) 87 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Hours	IF UNDER 24 HRS Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker -- Retired		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Boston Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Mr. George Averill		14. MOTHER'S MAIDEN NAME Mrs. Georgianna Kendall						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		INFORMANT Mr. Grant A. Wood		Address 8712 Colesville Road, Apt. 408 Silver Spring, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		DUE TO longevative heart failure				INTERVAL BETWEEN ONSET AND DEATH 4 years		
Conditions, if any which gave rise to immediate cause (a), stating the under- lying cause lost. Arteriosclerotic heart disease		DUE TO (b)				INTERVAL BETWEEN ONSET AND DEATH 6 years		
DUE TO (c)								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 				19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) 		(County) (State)
21. I certify that I attended the deceased from March 1957 to June 12, 1961 , that I last saw the deceased alive on June 11, 1961 , and that death occurred at 7:10 AM , from the causes and on the date stated above								
ADDRESS (Street, city or town, state) 927 Pershing Drive, Silver Spring, Maryland								
DATE SIGNED Scorah T. Kimble M.D. 927 Pershing Drive, Silver Spring 6-12-66								
ACTUAL SIGNATURE Scorah T. Kimble		PHYSICIAN'S NAME (Type) Scorah T. Kimble						
22a. BURIAL, CREMATON, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/14/61		22c. NAME OF CEMETERY OR CREMATORIUM Rock Creek Cemetery		22d. LOCATION (City, town, or county) Washington D.C.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey Inc.		ADDRESS 8434 Georgia Avenue Raymond A. Black		24a. REC'D BY REGISTRAR JUN 15 '61		24b. REGISTRAR'S SIGNATURE Curthia S. Krause		



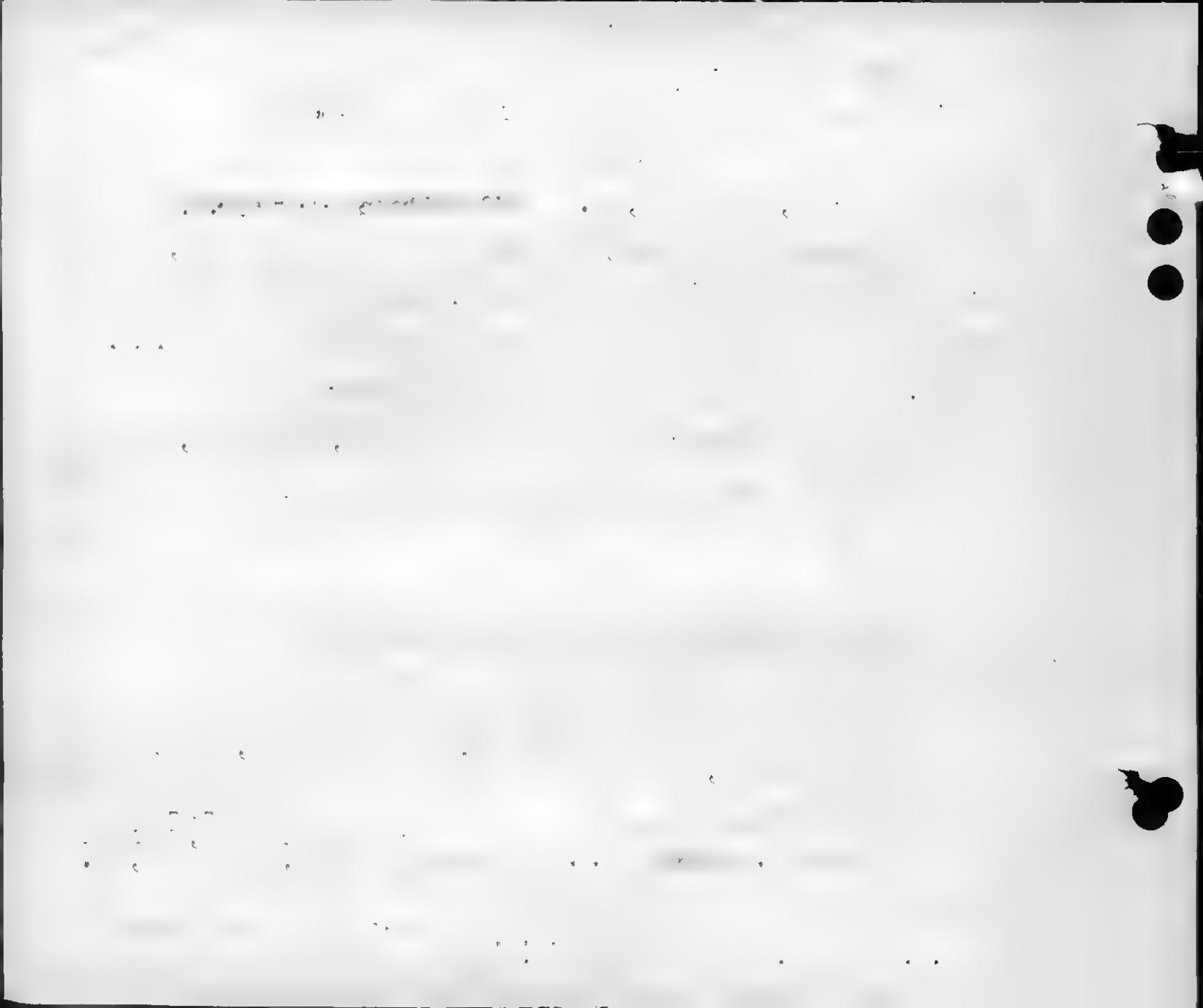
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07046

7059

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE District Of Columbia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 18 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 1721 Kilbourne Place, N.W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Harlan	Middle (None)	Last Wood	4. DATE OF DEATH	Month June	Day 12,	Year 19 61
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 4, 1896	9. AGE (In years at birthday) 65	10. IF UNDER 1 YEAR yrs. Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Attorney		10b. KIND OF BUSINESS OR INDUSTRY Law		11. BIRTHPLACE (State or foreign country) Spartanburg, South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John C. Wood				14. MOTHER'S MAIDEN NAME Caroline Cannon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes No, or Unknown) Yes		16. SOCIAL SECURITY NO. WW I Unascertainable		17. INFORMANT The Medical Records		address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brachogenic carcinoma, disseminated DUE TO 162.1 INTERVAL BETWEEN ONSET AND DEATH mos. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Aortic insufficiency, myocardial infarction							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 25, 1961 to June 12, 1961 , that (I) (we) last saw the deceased alive on June 12, 1961 , and that death occurred at 5:59 P.M. from the causes and on the date stated above							
22a. SIGNATURE Michael W. Brandriss				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 6-12-61	
22c. PHYSICIAN'S NAME (Type) Michael W. Brandriss M.D.				22d. ADDRESS The Clinical Center, National Institutes Of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/16/1961		23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cemetery		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901 14th St., N.W.				ADDRESS Wash. D.C.		25a. REC'D BY REGISTRAR	25b. REC'D BY REGISTRAR'S SIGNATURE Arthur S. Thomas
						DATE JUN 14 '61	

TO HOSPITAL OR CLINIC: The law requires that the death certificate be executed by a physician or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11 & 12 Film G289 6/27/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. 07047

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
<i>Montgomery, Maryland</i>		<i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
<i>Takoma Park</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
<i>Cedar Haven Rest Home</i>		<i>8505 Flower Ave</i>	
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Evelyn</i>		<i>B</i>	<i>Wright</i>
3. NAME OF DECEASED (Type or print)		Last	4. DATE OF DEATH
<i>Evelyn</i>		<i>Wright</i>	June 19 1961
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
<i>Female</i>	<i>White</i>	<i>WIDOWED</i> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<i>Feb 1 1879</i>
9. AGE (In years lost birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
<i>82</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>New York</i>		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>William Boughton</i>		<i>Julia Terwilliger</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
		17. INFORMANT	
		<i>W. Albert Wright</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
<i>443 X</i>			
DUE TO			
<i>Cerebral Hemorrhage</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			
(b) <i>Hypertensive Heart Disease</i>			
DUE TO			
<i>Arteriosclerosis</i>			
INTERVAL BETWEEN ONSET AND DEATH			
<i>years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
<i>Smoking</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>Oct 21, 1960</i> , to <i>June 19, 1961</i> , that I last saw the deceased alive on <i>June 18, 1961</i> , and that death occurred at <i>2:30 A.M.</i> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)			
DATE SIGNED			
<i>Philip E. Jones M.D. 918 Ellsworth Drive 6-19-61</i>			
ACTUAL SIGNATURE			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<i>Burial</i>		<i>June 22, 1961</i>	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
<i>Arlington National Cemetery</i>		<i>Arlington, Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
<i>Arthur Walters, 254 Carroll St NW, D.C.</i>		24b. REGISTRAR'S SIGNATURE	
		DATE JUN 21 '61	

TO HOSPITAL OR HOSPITAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after the deceased has been admitted to a hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7061

07048

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1		2		3	
M C <i>(51)</i>		Herman ZIFFER		Kathleen Mary MORRISON	
1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Baby Girl		4. DATE OF DEATH June 23 1961			
5. SEX Female		6. COLOR OR RACE Caucasian			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 6-21-61			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) yrs. Months 2 Days 2 Hours 2 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Herman ZIFFER		14. MOTHER'S MAIDEN NAME Kathleen Mary MORRISON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None			
17. INFORMANT (F) Herman Ziffer, same as #2 above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776 X Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost.		DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from.....June 21.....1961 to.....June 23.....1961, that (b) (we) last saw the deceased alive on.....June 23.....1961, and that death occurred at 9A.M. from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
22e. SIGNATURE <i>Robert V. Rack</i>		22b. DATE SIGNED 6-23-61			
22c. PHYSICIAN'S NAME (Type) Robert V. RACK, LT, MC, USN		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 26 Jun 61			
23c. NAME OF CEMETERY OR CREMATORIAL J. Wm. Lee's Sons Co.		23d. LOCATION (City, town or county) Washington, D. C. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Everly Funeral Home, Fairfax, Va.</i>		25a. REC'D BY REGISTRAR DATE JUN 27 '61			
		25b. REGISTRAR'S SIGNATURE Arthur S. Krause			

VR A15 (4)
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July 1980

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